01-1704-005
DIANE LEBRUN
JVW

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar Amend Item#24a perVERBALG796 6/29/01 EW AMEND ITEM 23a & 27 per ME G794 04250 SS

Certificate of Death

Reg. No. 2001 10001

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)			2. Date of Death Month Day Year	3. Time of Death
Diane	Patrice	LeBrun	MARCH 28,2001	04:02 AM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
8126 STRATMAN ROAD	NORTHPOINT	BALTIMORE

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
220-68-3356	1☐M 2☒F	42 Yrs.			April 19,1958	Maryland

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Baltimore	Dundalk	1☐Yes 2☒No

10e. Street and Number	10f. Zip Code	10g. Citizen of Whet Country?
8126 Stratman Road	21222	U.S.A.

11. Marital Status	12. Wes Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.)	14. Rece - American Indian, Bleck, White, etc.
1☐Never Married 2☒Married 3☐Widowed 4☐Divorced	1☐Yes 2☒No If Yes, Give Year or Dates:	1☐Yes 2☒No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	18b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12 yr's		Home Maker	Own Home

17. Father's Name (First, Middle, Last)	18. Mother's Neme (First, Middle, Maiden Surneme)
Glendine S. Canon	Thelma M. Freitag

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Mr. Paul E. LeBrun - Husband	8126 Stratman Road Dundalk, Maryland 21222

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, cremetory or other piece)	Date	20c. Location - City or Town, Stete
1☒Burial 2☐Cremation 3☐Removel from Stete 4☐Donation 5☐Other (Specify)	Parkwood Cemetery	3/30/01	Baltimore,MD

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ Paul L Hartsock Jr	Baltimore, Maryland 21214 Leonard J. Ruck, Inc. 5305 Harford Rd.

Physician /Medical Examiner

23a. Part1. Enter the diseese, or complicatons that caused the death. Do not enter the mode of dying, such as cardiec or respiratory errest, shock, or heert feilure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. REACTIVE AIRWAY DISEASE IN ASSOCIATION WITH FATTY METAMORPHOSIS OF THE LIVER AND KETOSIS

Sequentially list conditions, if any, leading to immediete cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or es e consequence of):

IF FEMALE: 23b. Was decedent pregnant in the pest 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month Dey Year
1☐Yes 2☐No 9☐Unknown	1☐Live birth 2☐Fetel death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probebly 4☐Unknown

24e. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☒Yes 2☐No	1☐Yes 2☐No

25. Was case referred to medical examiner?	28. Place of Death (Check only one)	
1☒Yes 2☐No	Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA	Other: 4☐Nursing Home 5☐Residence 6☒Other (Specify) SCENE

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined		M	1☐Yes 2☐No	

28e. Place of Injury - At home, tarm, street, factory, office building, etc. (Specify)	28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one)
1☐ **Certifying Physician:** To the best of my knowledge, death occurred et the time, date and place, and due to the cause(s) end menner as stated.
2☒ **Medical Examiner:** On the basis of examinalion and/or investigation, in my opinion, death occurred al the time, dete and piece, end due to the cause(s) and manner stated.

29b. Signature end title of certifier	29c. License number	29d. Date signed (Month, Dey, Yeer)
▶ M.D.	O.C.M.E.	MARCH 28,2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
MARY C. RIPPLE, M.D. 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Dey, Yeer)	32. Registrar's Signature
APR 02 2001	▶ G Sparks

DHMH 17 Rev 1/2001

ORIGINAL

To Be Completed by Funeral Director

Medical Certification; To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than 'natural', or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 10002

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Thomas Francis Lanasa

2. Data of Death Month Day Year: March 28, 2001

3. Time of Death: 10:33 AM

4a. Facility Name *(If not institution, give street and number)*: Good Samaritan Hospital

4b. City, Town, or Location of Death: Baltimore City

4c. County of Death: N/A

Funeral Director

5. Social Security Number: 220-22-3087

8. Sex: 1☒ M 2☐ F

7. Age *(In yrs. last birthday)*: 71 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Data of Birth *(Month, Day, Year)*: June 28, 1929

9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: N/A

10c. City, Town or Location: Baltimore City

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 2813 Hemlock Avenue

10f. Zip Code: 21214

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☒ Yes 2☐ No If Yes, Give Year or Dates: WW II

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 yr's; College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Port Administration

16b. Kind of Business/Industry: State of Maryland

17. Father's Name *(First, Middle, Last)*: Michael J. Lanasa

18. Mother's Name *(First, Middle, Maiden Surname)*: Mary Mullen

19a. Informant's Name/Relationship *(Type, Print)*: Marjorie R. Lanasa - Wife

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 2813 Hemlock Avenue Baltimore, MD 21214

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Parkwood Cemetery

Date: 3/31/01

20c. Location - City or Town, State: Baltimore, MD

21. Signature of Funeral Service Licensee: ▶ Paul L Hartsock Jr

22. Name and Address of Facility: Baltimore, Maryland 21214

Leonard J. Ruck, Inc. 5305 Harford Rd.

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Respiratory Failure

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. COPD

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☒ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☒ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29e. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ A Weiner MD

29c. License number: D26475

29d. Date signed *(Month, Day, Year)*: 3/29/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): G. WEINER MD. 9512 Harford Rd Balto. md

State Registrar

31. Date filed *(Month, Day, Year)*: APR 0 2 2001

32. Registrar's Signature: ▶ Geneva G Sparks

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

DHMH 16 Rev 6/95

ORIGINAL

01-1581-033
B.K.S
TERRY McKENNEY

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar AMEND ITEM #1,23a,b,27 per ME G794 042001 SS

Certificate of Death

Reg. No. 2001 10003

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): TERRY WAYNE MC KENNEY JR. (Terry McKenny Jr.)
2. Date of Death (Month, Day, Year): MARCH 21, 2001
3. Time of Death: 10:40a M
4a. Facility Name (If not institution, give street and number): GREATER LAUREL BELTSVILLE HOSPITAL
4b. City, Town, or Location of Death: BELTSVILLE
4c. County of Death: PRINCE GEORGES

Funeral Director

5. Social Security Number: 220-94-8869
8. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 21 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): DEC. 31, 1979
9. Birthplace (State or Foreign Country): MARYLAND

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: MARYLAND
10b. County: N/A
10c. City, Town or Location: BALTIMORE CITY
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 321 E. 27TH STREET
10f. Zip Code: 21218
10g. Citizen of What Country?: USA.

11. Marital Status: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12): 9TH GRADE
College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): N/A
18b. Kind of Business/Industry: N/A

17. Father's Name (First, Middle, Last): TERRY WAYNE MCKENNEY SR.
18. Mother's Name (First, Middle, Maiden Surname): SHELIA MADISON

19a. Informant's Name/Relationship (Type, Print): SHELIA MADISON (MOTHER)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 321 EAST 27TH STREET, BALTIMORE, MD. 21218

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): MT. ZION CEMETERY
Date: 03-31-01
20c. Location - City or Town, State: LANDOWNE, MARYLAND

21. Signature of Funeral Service Licensee: Ruth N. Williams
22. Name and Address of Facility: JOSEPH H. BROWN JR. FUNERAL HOME 2140 N. FULTON AVE., BALTO, MD. 21217

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death):
a. CARDIAC ARRHYTHMIA
Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b. CARDIAC HYPERTROPHY AND DILATATION
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1 [ ] Yes 2 [X] No 9 [ ] Unknown
23c. If yes, outcome of pregnancy: 1 [ ] Live birth 2 [ ] Fetal death 3 [ ] Ectopic pregnancy 4 [ ] Pregnant at time of death 5 [ ] Other (specify) 9 [ ] Unknown
23d. Date of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Part I.

23e. Did tobecco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [X] Yes 2 [ ] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [X] Yes 2 [ ] No

Medical Certification; To Be Completed by Physician/Medical Examiner

25. Was case referred to medical examiner? 1 [X] Yes 2 [ ] No

28. Place of Death (Check only one)
Hospital: 1 [ ] Inpatient 2 [X] ER/Outpatient 3 [ ] DOA
Other: 4 [ ] Nursing Home 5 [ ] Residence 8 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [ ] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [X] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, dete and place, and due to the ceuse(s) and manner stated.

29b. Signature end title of certifier: Dennis J. Chutkow
29c. License number: O.C.M.E
29d. Date signed (Month, Day, Year): MARCH 22, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Dennis Chutkow 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year): APR 2 2001
32. Registrar's Signature: Geneva B. Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

AMEND ITEM 23a per phys G794 040201 SS

Certificate of Death

Reg. No. 2001 10004

Patient known as: McMackin, Raymond

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): RAYMOND McMAKIN

2. Date of Death: Month March Day 19 Year 2001

3. Time of Death: 11:40 PM

4a. Facility Name (If not institution, give street and number): Sinai Hospital

4b. City, Town, or Location of Death: Baltimore

4c. County of Death:

Funeral Director

5. Social Security Number: 248-22-2713

6. Sex: 1☑ M 2☐ F

7. Age (In yrs. last birthday): 76 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): 8-20-24

9. Birthplace (State or Foreign Country): GREER S. C.

Usual Residence of Decedent

10a. State: Md

10b. County:

10c. City, Town or Location: BALTO.

10d. Inside City Limits: 1☑ Yes 2☐ No

10e. Street and Number: 5338 BEAUFORT AVE

10f. Zip Code: 21215

10g. Citizen of What Country? USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☑ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☐ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☑ No Specify:

14. Race - American Indian, Black, White, etc. Specify: BLACK

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 9th; College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): CUSTODIAN

16b. Kind of Business/Industry: Construction

17. Father's Name (First, Middle, Last): WASHINGTON McMAKIN

18. Mother's Name (First, Middle, Maiden Surname): HATTIE COLEMAN

19a. Informant's Name/Relationship (Type, Print): HATTIE QUEEN

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 5338 BEAUFORT AVE BALTO MD. 21215

20a. Method of Disposition: 1☑ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): MT CARMEL

Date: 3/24/01

20c. Location - City or Town, State: DUNDALK MD.

21. Signature of Funeral Service Licensee: Wesley Chandi

22. Name and Address of Facility: CHAVIS F.H. 2007 EASTERN AVE BALTO. MD. 21231

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Cardio Pulmonary Arrest

Due to (or as a consequence of): CORONARY ARTERY DISEASE

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b. ~~Coronary Artery Disease~~

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Prostate cancer with metastasis

~~Coronary artery disease~~

Cerebrovascular accident

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☑ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death (Check only one): Hospital: 1☑ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

29a. Certifier (Check only one): 1☑ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Roluardo Falcon M.D.

29c. License number: RES0000651

29d. Data signed (Month, Day, Year): 03/19/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Roluardo Falcon 2401 West Belvedere, Baltimore MD 21215

State Registrar

31. Date filed (Month, Day, Year): APR 0 2 2001

32. Registrar's Signature: Geneva G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 10005

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): ALPHONSE IGNATIUS MILWICZ

2. Date of Death (Month, Day, Year): MARCH 29, 2001

3. Time of Death: 11:45 AM

4a. Facility Name (If not institution, give street and number): 1455 MARYLAND AVE.

4b. City, Town, or Location of Death: SEVERN

4c. County of Death: ANNE ARUNDEL

Funeral Director

5. Social Security Number: 217-26-0434

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 71 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): JULY 31, 1929

9. Birthplace (State or Foreign Country): ODENTON, MD

Usual Residence of Decedent

10a. State: MD

10b. County: ANNE ARUNDEL

10c. City, Town or Location: SEVERN

10d. Inside City Limits: 1 [ ] Yes 2 [ ] No XX

10e. Street and Number: 1455 MARYLAND AVE.

10f. Zip Code: 21144

10g. Citizen of What Country? USA

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Yeer or Dates: 46-49

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Reca - American Indien, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementery/Secondary (0-12): 12 | College (1-4or 5+):

16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): BOTTLE MANAGER

16b. Kind of Business/Industry: BEVERAGE

17. Fether's Name (First, Middle, Last): JOSEPH MILWICZ

18. Mother's Name (First, Middle, Maiden Surneme): FRANCES F. SHAI

19a. Informant's Name/Reletionship (Type, Print): AVIS D. MILWICZ WIFE

19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code): 1455 MARYLAND AVE. SEVERN, MD 21144

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremetion 3 [ ] Removal from Stete 4 [ ] Donetion 5 [ ] Other (Specify)

20b. Piece of Disposition (Neme of cemetery, cremetory or other piace): GLEN HAVEN CEMETERY

Dete: 4-02-01

20c. Location - City or Town, Stete: GLEN BURNIE, MD

21. Signeture of Funeral Service Licensee: Patrick J. Hall II

22. Neme end Address of Fecility: HARDESTY FUNERAL HOME P.A. 851 ANNAPOLIS RD. GAMBRILLS, MARYLAND 21054

Physician /Medical Examiner

23a. Pert1. Enter the disease, or complicetions that caused the deeth. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heart feilure. List only one ceuse on each line.

Approximate Interval Between Onset and Death

Immediete Cause (Finel disease or condition resulting in death)
e. Rectal Cancer metastatic To — 22 years

Due to (or as a consequenca of):
Liver

Sequentially tist conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b.

Due to (or es a consequenca of):
c.

Due to (or as e consequence of):
d.

Pert It. **Other significant conditions** contributing to deeth but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contributs to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24e. Wes en autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were eutopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Wes case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Piece of Death (Check only one): Hospitel: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | Other: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigetion 6 [ ] Could not be determined

28a. Dete of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how Injury occurred

28e. Piece of Injury - At home, ferm, street, fectory, offica building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1 [X] **Certifying Physician**: To the best of my knowledge, deeth occurred at the time, dete and piece, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner**: On the basis of examinetion and/or investigetion, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) and menner steted.

29b. Signeture end title of certifier: Mayer Gorbotz MD

29c. License number: D27938

29d. Date signed (Month, Day, Year): March 30, 2001

30. Nema and eddress of person who completed cause of death (Item 23e) (Type, Print): Mayer Gorbotz M.D. 745 Aquahurst Rd. Glen Burnie MD 21061

State Registrar

31. Dete filed (Month, Day, Yeer): APR 02 2001

32. Registrer's Signature: Geneva G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 25a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Amend Item 24a,26,27 per Dr,G79404/02/01dhb

Certificate of Death

Reg. No. 2001 10006

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): James G. Miller
2. Date of Death: Month March, Day 1, Year 2001
3. Time of Death: 8:20 AM
4a. Facility Name (If not institution, give street and number): 1101 Queens Purchase Road #H
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 013-28-0610
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 65 Yrs. | If Under 1 Year: Months, Days | If Under 24 Hrs.: Hours, Min.
8. Date of Birth (Month, Day, Year): Nov 23, 1935
9. Birthplace (State or Foreign Country): MASS

Usual Residence of Decedent

10a. State: MD
10b. County: Baltimore
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 1101 Queen Purchase Road #H
10f. Zip Code: 21221
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☒ Yes 2☐ No If Yes, Give Year or Dates: '53-59
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: white

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 10 | College (1-4or 5+): 0
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): laborer
16b. Kind of Business/Industry: construction

17. Father's Name (First, Middle, Last): James Harrison Miller
18. Mother's Name (First, Middle, Maiden Surname): Louise May Miskinis

19a. Informant's Name/Relationship (Type, Print): Judy Thomas/daughter
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4369 Huntington Forest Blvd Jackson, FL 32257

20a. Method of Disposition: 1☐ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☒ Other (Specify) in state
20b. Place of Disposition (Name of cemetery, crematory or other place):
Date:
20c. Location - City or Town, State:

21. Signature of Funeral Service Licensee: Joseph B. Van Sant
22. Name and Address of Facility: State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. AIDS — >5years

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day, Year)
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Mary-Claire Roghmann
29c. License number: D42585
29d. Date signed (Month, Day, Year): 3/23/01

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): MARY-CLAIRE ROGHMANN 10 N GREENE ST BALTIMORE MD

State Registrar

31. Date filed (Month, Day, Year): APR 0 2 2001
32. Registrar's Signature: Geneva G Sparks

DHMH 16 Rev 6/95

ORIGINAL

To be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 10007

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Rayford McEachern

2. Date of Death: Month March Day 29 Year 2001

3. Time of Death: 0150 A.M.

4a. Facility Name (If not institution, give street and number): Gilchrist Center For Hospice Care

4b. City, Town, or Location of Death: Baltimore

4c. County of Death:

Funeral Director

5. Social Security Number: 249-46-6493

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 68 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): 09/06/1932

9. Birthplace (State or Foreign Country): North Carolina

Usual Residence of Decedent

10a. State: Maryland

10b. County:

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1 [X] Yes 2 [ ] No

10e. Street and Number: 48 N. Morley Street

10f. Zip Code: 21229

10g. Citizen of What Country? U.S.A.

11. Maritel Stetus: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Wes Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Yeer or Dates:

13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grede completed): Elementery/Secondary (0-12): 10 / College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Selector

16b. Kind of Business/Industry: Giant Food Warehouse

17. Father's Neme (First, Middle, Last): Moses McEachern

18. Mother's Name (First, Middle, Maiden Surname): Mabel Roberts

19a. Informant's Name/Reletionship (Type, Print): Genell McEachern / Wife

19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code): 48 N. Morley St., Baltimore, Maryland 21229

20a. Method of Disposition: 1 [X] Buriel 2 [ ] Cremetion 3 [ ] Ramovel from Stete 4 [ ] Donetion 5 [ ] Other (Specify)

20b. Place of Disposition (Neme of cemetery, cremetory or other piece): Woodlawn Cemetery

Dete: 04/04/01

20c. Location - City or Town, Stete: Woodlawn, Maryland

21. Signature of Funerel Service Licensee: Derrick C. Jones

22. Name end Address of Facility: Derrick C. Jones Funeral Home 4611 Park Hgts. Ave., Baltimore, Maryland 21215

Physician /Medical Examiner

23a. Part1. Enter the diseese, or complicetions that caused the deeth. Do not enter the mode of dying, such es cerdiac or respiretory errest, shock, or heart failure. List only one ceuse on eech line.

Approximate Interval Between Onset and Deeth

Immediete Cause (Finel disease or condition resulting in death): a. renal cell cancer — 15 mos

Due to (or es a consequence of):

Sequentially list conditions, if sny, leading to immediete cause. Entar Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequenca of):

c.

Due to (or es e consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobecco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Wes case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospitel: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [X] Other (Specify) Hospice

27. Manner of Death: 1 [X] Netural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigetion 6 [ ] Could not be determined

28a. Dete of Injury (Month, Dey Year)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify)

28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

Medical Certification: To Be Completed by Physician/Medical Examiner

29e. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, date and place, end due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examinetion and/or investigetion, in my opinion, deeth occurred at the time, date and pleca, and dua to the cause(s) end menner stated.

29b. Signeture and title of certifier: [signature] MD

29c. License number: D25205

29d. Dete signed (Month, Dey, Year): March 29, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): W. A. Riley GBMC 6701 N. Charles St Balto. md 21204

State Registrar

31. Date filed (Month, Day, Year): APR 2 0 2001

32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

ORIGINAL

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Rayford McEachern March 29, 2001 0150h

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 10008

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): STEWART J. PHIPPS
2. Date of Death (Month, Day, Year): March 19, 2001
3. Time of Death: 3:20 PM
4a. Facility Name (If not institution, give street and number): 1014 Wharf Road
4b. City, Town, or Location of Death: Arnold
4c. County of Death: Anne Arundel

Funeral Director

5. Social Security Number: 219-30-8012
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 74 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): May 3, 1926
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: MD
10b. County: Anna Arundel
10c. City, Town or Location: Arnold
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10a. Street and Number: 1014 Wharf Road
10f. Zip Code: 21012
10g. Citizen of What Country: USA

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: '43-46
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: white

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+): 0
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): auto mechanic
16b. Kind of Business/Industry: auto dealership

17. Father's Name (First, Middle, Last): Jefferson Phipps
18. Mother's Name (First, Middle, Maiden Surname): Helen Elizabeth Stelljies

19a. Informant's Name/Reletionship (Type, Print): Carol Phipps/spouse
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1014 Wharf Road Arnold, MD 21012

20a. Method of Disposition: 1 [ ] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [X] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, cremetory or other place):
Date:
20c. Location - City or Town, State:

21. Signature of Funeral Service Licensee: Joseph B. Van Sant
22. Name and Address of Facility: State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death):
a. MYOCARDIAL INFARCTION
Due to (or as a consequence of):
b. hypertension
Due to (or as a consequence of):
c. hyperlipidemia
Due to (or as a consequence of):
d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No
26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [X] DOA | Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [X] Other (Specify) Home

27. Manner of Death: 1 [X] Naturel 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day Year):
28b. Time of Injury:
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred:
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify):
28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1 [X] **Certifying Physician**: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature end title of certifier: Thomas Walsh M.D
29c. License number: D23867
29d. Date signed (Month, Day, Year): 3-26-01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): THOMAS WALSH MD 277 Peninsula Farm Road ARNOLD MD 21012

State Registrar

31. Date filed (Month, Day, Year): APR 02 2001
32. Registrar's Signature: Jennie G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

AMND ITM#19a PR. INFMNT G794 4-11-01 JAB

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar Amend Item#5 perFHG794 4/6/2001 EW **Certificate of Death**

Reg. No. 2001 10009

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
Ruth C. Pullen	March 31, 2001	9:15 P M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Manor Care	Towson	Baltimore

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
~~220-09-0561~~ ~~020-04-9261~~	1☐M 2☒F	88 Yrs.			4/25/1912	Maryland

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	Baltimore	Towson	1☐Yes 2☒No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
7001 Charles Street		USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐Never Married 2☐Married 3☒Widowed 4☐Divorced	1☐Yes 2☒No If Yes, Give Year or Dates:	1☐Yes 2☒No Specify:	Specify: white

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12		Homemaker	Own Home

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Louis Kaufman	Mary Margaret Burke

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
~~Mary Fitzgerald - daughter~~ DELBERT FITZGERALD - NEPHEW	3409 Lambros Road, Baltimore, MD 21234

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	Glen Haven Mem. PK	4/4/2001	Glen Burnie, MD

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
Kelly Gregory Fink	FINK FUNERAL HOME, PA 426 Crain Hwy., SW, Glen Burnie, MD 21061

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Arch Themis	3 Months
Sequentially list conditions, if any, leading to immediete cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	b. Due to (or as a consequence of):	
	c. Due to (or as a consequence of):	
	d. Due to (or as a consequence of):	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month Day Year
1☐Yes 2☒No 9☐Unknown	1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Part I.

23e. Did tobacco use contribute to the ceuse of death? 1☐Yes 2☐No 3☐Probably 4☒Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐Yes 2☒No	1☐Yes 2☒No

25. Wes case referred to medical examiner?	26. Place of Death (Check only one)	
1☐Yas 2☒No	Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA	Other: 4☒Nursing Home 5☐Residence 8☐Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work?	28d. Describe how injury occurred
1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined			1☐Yes 2☐No	
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification; To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one) 1☒**Certifying Phyalcian:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the ceusa(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Yaar)
	D45475	4-2-01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M Kahrama---8100 Harford Rd. Balto MD 21234

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
APR 02 2001	Denise G Sparks

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: Tha law requiras that the death certificate be axecuted within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be datached for usa as the burial-transit

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 10010

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Mildred Kathleen Porea
2. Date of Death (Month, Day, Year): April 2, 2001
3. Time of Death: 12:10 AM
4a. Facility Name (If not institution, give street and number): Manor Care Ruxton
4b. City, Town, or Location of Death: Towson
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 176-09-4719
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 90 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Aug 3, 1910
9. Birthplace (State or Foreign Country): Pennsylvania

Usual Residence of Decedent

10a. State: MD
10b. County: Baltimore
10c. City, Town or Location: Reisterstown
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 222 Highmeadow Road
10f. Zip Code: 21136
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+): -0-
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Secretary
16b. Kind of Business/Industry: Education

17. Father's Name (First, Middle, Last): Frank T. Eberlin
18. Mother's Name (First, Middle, Maiden Surname): Emma McGee

19a. Informant's Name/Relationship (Type, Print): John T. Porea, III /Son
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 222 Highmeadow Road Reisterstown, MD 21136

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Carroll Cremation Serv
Date: 4/5/01
20c. Location - City or Town, State: Hampstead, Maryland

21. Signature of Funeral Service Licensee: Thomas B Eline
22. Name and Address of Facility: Eline Funeral Home 11824 Reisterstown Road Reisterstown, MD 21136

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) a.	Acute Myocardial Infarction	1 day
Due to (or as a consequence of):		
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b.		
Due to (or as a consequence of):		
c.		
Due to (or as a consequence of):		
d.		

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier:
29c. License number: D-12849
29d. Date signed (Month, Day, Year): 4-2-01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): A.H. CHILADIS, MD. 7600 OSLER Dr. Towson Md 21204

State Registrar

31. Date filed (Month, Day, Year): APR 02 2001
32. Registrar's Signature: Donna G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 10011

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Gwendolyn E. Pulley
2. Date of Death: Month March Day 29, 2001 Year
3. Time of Death: 1540
4a. Facility Name (If not Institution, give street and number): Maryland General Hospital
4b. City, Town, or Location of Death: Baltimore City
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 218-62-5792
6. Sex: 1☐ M 2☑ F
7. Age (In yrs. last birthday): 46 Yrs. If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Sept. 1, 1954
9. Birthplace (State or Foreign Country): Durham, N.C.

Usual Residence of Decedent

10a. State: Md.
10b. County: N/A
10c. City, Town or Location: Baltimore City
10d. Inside City Limits: 1☒ Yes 2☐ No
10a. Street and Number: 824 W. Northave.
10f. Zip Code: 21217
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): ; College (1-4or 5+): 3 yrs
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Home Health Care
16b. Kind of Business/Industry: Self Employed

17. Father's Name (First, Middle, Last): Robert H. Jordan
18. Mother's Name (First, Middle, Maiden Surname): Bessie P. Russell

19a. Informant's Name/Relationship (Type, Print): Yolanda Pulley
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 824 W. North. Ave. Balto. Md. 21217

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Metro Crematory Date: 3-30-01
20c. Location - City or Town, State: Baltimore, Md.

21. Signature of Funeral Service Licensee: James A. Morton II
22. Name and Address of Facility: James A. Morton + Sons, Inc 1701 Laurens St.

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Septic Shock
Due to (or as a consequence of):
b. Cirrhosis of Liver

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No
26. Place of Death (Check only one): Hospital: 1☑ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☑ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier:
29c. License number: P 13526
29d. Date signed (Month, Day, Year): 3/29/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Eric Marcalus, M.D. % Maryland General Hospital

State Registrar

31. Date filed (Month, Day, Year): APR 02 2001
32. Registrar's Signature: Geneva G Sparks

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

Gwendolyn Pulley

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 10012

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
Linda Elizabeth Peyton	March 30, 2001	1:35 p.m.

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Johns Hopkins - Bayview Medical Ctr.	Baltimore	

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
214-44-7316	1☐M 2☒F	54 Yrs.			Aug. 18, 1946	Maryland

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Baltimore	Dundalk	1☐Yes 2☒No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
2069 Larkhall Road	21222	U.S.A.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐Never Married 2☒Married 3☐Widowed 4☐Divorced	1☐Yes 2☒No If Yes, Give Year or Dates:	1☐Yes 2☒No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12		Housewife	Own Home

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
William Howard Gudgeon	Erma Agnes Sheldon

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Colleen Hirsch (daughter)	44 Maple Court, Elkton, Maryland 21921

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	Holly Hill Mem. Gardens	4/3/2001	Baltimore, Maryland

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
	Bruzdzinski Funeral Home, P.A. 1407 Old Eastern Avenue, Essex, Maryland 21221

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Chronic Obstructive Lung Disease.	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of): b. Pulmonary Hypertension	
	Due to (or as a consequence of): c.	
	Due to (or as a consequence of): d.	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month Day Year
1☐Yes 2☒No 9☐Unknown	1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?	24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐Yes 2☐No 3☐Probably 4☒Unknown	1☐Yes 2☒No	1☐Yes 2☐No

25. Was case referred to medical examiner?	28. Place of Death (Check only one)	
1☐Yes 2☒No	Hospital: 1☐Inpatient 2☒ER/Outpatient 3☐DOA	Other: 4☐Nursing Home 5☐Residence 8☐Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined		M	1☐Yes 2☐No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
Gregory B. Kelly MD	D21242	March 31, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Gregory B Kelly MD 4924 Campbell Blvd. Baltimore, MD 21236.

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
APR 02 2001	Brenda G Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Medical Certification; To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

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To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

1- For State Registrar

Reg. No. 2001 | 0013

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): RITA REKOSKI

2. Date of Death Month Day Year: MARCH 30, 2001

3. Time of Death: 2:00 A.M

4a. Facility Name (If not institution, give street and number): Union Memorial Hospital

4b. City, Town, or Location of Death: Baltimore

4c. County of Death:

Funeral Director

5. Social Security Number: 218-26-3607

6. Sex: 1☐M 2☑F

7. Age (In yrs. last birthday): 70 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): 07/ 06/ 1930

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Harford

10c. City, Town or Location: Bel Air

10d. Inside City Limits: 1☐Yes 2☑No

10e. Street and Number: 1500 Briarhill Estates Drive

10f. Zip Code: 21015

10g. Citizen of What Country? United States

11. Marital Status: 1☐Never Married 2☐Married 3☐Widowed 4☑Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐Yes 2☑No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☑No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 / College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker

16b. Kind of Business/Industry: Domestic

17. Father's Name (First, Middle, Last): Russell Harbaugh

18. Mother's Name (First, Middle, Maiden Surname): Helen Grochowski

19a. Informant's Name/Relationship (Type, Print): David Rekoski/ Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4020 Cloverland Drive, Pheonix Maryland 21131

20a. Method of Disposition: 1☑Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Scared Heart of Jesus 4/3

Date:

20c. Location - City or Town, State: Baltimore Maryland

21. Signature of Funeral Service Licensee: ▶ Kathleen Weber CFSP

22. Name and Address of Facility: David J. Weber Funeral Homes PA 401 S. Chester Street, Baltimore Maryland 21231

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. PNEUMONIA — 3 WEEKS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1☐Yes 2☑No 9☐Unknown

23c. If yes, outcome of pregnancy: 1☐Live birth 2☐Fatal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown

23d. Date of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: RENAL FAILURE

23a. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☐Unknown

24a. Was an autopsy performed? 1☐Yes 2☐No

24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☐No

25. Was case referred to medical examiner? 1☐Yes 2☐No

26. Place of Death (Check only one): Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death: 1☑Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury: M

28c. Injury at Work? 1☐Yes 2☐No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification; To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☑**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ [signature] MD

29c. License number: D47123

29d. Date signed (Month, Day, Year): MARCH 30, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): JOSEPH PUTTHUMANA, UNION MEM HOSP 201 E. UNIV. PKWY BALTIMORE, MD 21218

State Registrar

31. Date filed (Month, Day, Year): APR 02 2001

32. Registrar's Signature: [signature]

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28d show any injury or other traumatic event, the Medical Examiner must be notified at once.

To be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 10014

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Helen A. Robinson
2. Date of Death (Month, Day, Year): March 29, 2001
3. Time of Death: 1:45 AM
4a. Facility Name (If not institution, give street and number): 2401 Orleans St.
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 212-28-0842
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 71 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Sept. 8, 1929
9. Birthplace (State or Foreign Country): New York

Usual Residence of Decedent

10a. State: Maryland
10b. County: N/A
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 2401 Orleans St.
10f. Zip Code: 21224
10g. Citizen of What Country? USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: African American

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4or 5+): 0
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker
16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): Melvin Cornelius Sr.
18. Mother's Name (First, Middle, Maiden Surname): Mary Hubbard

19a. Informant's Name/Relationship (Type, Print): Ms. Antoinette Milton (daughter)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2401 Orleans St. Balto. Md. 21224

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Mt. Zion
Date: 4/4/2001
20c. Location - City or Town, State: Lansdowne, Md.

21. Signature of Funeral Service Licensee: Joseph L. Russ
22. Name and Address of Facility: Joseph L. Russ Funeral Home 2222 W. North Ave. Balto. Md. 21216

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. LUNG CANCER	7 MONTHS
	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	b.	
	Due to (or as a consequence of):	
	c.	
	Due to (or as a consequence of):	
	d.	

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: EMPHYSEMA, CORONARY ARTERY DISEASE

23b. Did tobacco use contribute to the cause of death? 1☒ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☒ Residence 8☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Nathan A Scott III, MD
29c. License number: D34484
29d. Date signed (Month, Day, Year): 3-29-01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): NATHAN A. SCOTT III, M.D. 1000 E. EAGER ST. BALTIMORE, MD 21202

State Registrar

31. Date filed (Month, Day, Year): APR 0 2 2001
32. Registrar's Signature: G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 20ca.

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 10015

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): LAURENCE Richmond

2. Date of Death: Month 03 Day 27 Year 01

3. Time of Death: 4:30 pm

4a. Facility Name (If not institution, give street and number): GENESIS MULTI MEDICAL

4b. City, Town, or Location of Death: TOWSON

4c. County of Death: BALTIMORE

Funeral Director

5. Social Security Number: 219-10-4036

6. Sex: 1 X M 2 ☐ F

7. Age (In yrs. last birthday): 75 Yrs.

If Under 1 Year: Months ____ Days ____

If Under 24 Hrs.: Hours ____ Min. ____

8. Date of Birth (Month, Day, Year): April 3, 1925

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: MD

10b. County: N/A

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1 X Yes 2 ☐ No

10e. Street and Number: 3808 Glenarm Avenue

10f. Zip Code: 21206

10g. Citizen of What Country?: U.S.A.

11. Meritel Stetus: 1 ☐ Never Married 2 X Married 3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 ☐ No If Yes, Give Year or Detes:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 X No Specify:

14. Race - American Indian, Bleck, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 12

College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Contractor

16b. Kind of Business/Industry: Flooring

17. Father's Name (First, Middle, Last): Laurence Richmond

18. Mother's Name (First, Middle, Maiden Surname): Agnes Genevieve McGreevy

19a. Informant's Neme/Relationship (Type, Print): Mrs. Maryl J. Richmond-wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3808 Glenarm Avenue Baltimore, Maryland 21206

20a. Method of Disposition: 1 X Burial 2 ☐ Cremetion 3 ☐ Removel from Stete 4 ☐ Donetion 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Garrison Forest Vet. Cem.

Date: 4/2/01

20c. Location - City or Town, State: Baltimore, Maryland

21. Signature of Funeral Service Licensee: Heather Cain

22. Name and Address of Facility: Leonard J. Ruck, Inc. 5305 Harford Road Baltimore, Maryland 21214

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart feilure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final diseese or condition resulting in death)

a. Stroke — weeks

Due to (or es a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury thet initiated events resulting in death) Last

b. Diabetes Mellitus — years

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Dementia

Hypertension

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown

24a. Wes en autopsy performed? 1 ☐ Yes 2 X No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 X No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other: 4 X Nursing Home 5 ☐ Residenca 6 ☐ Other (Specify)

27. Manner of Death: 1 X Netural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) and manner as stated. 2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated.

29b. Signature and title of certifier

29c. License number: D17118

29d. Date signed (Month, Day, Year): Mar 28, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Paul Schwarz MD 7701 York Rd 21204

State Registrar

31. Date filed (Month, Day, Year): APR 0 2 2001

32. Registrar's Signature: Jennifer Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 10016

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): OLIVER L. SLAUGHTER
2. Date of Death (Month, Day, Year): 03/26/2001
3. Time of Death: 15;15PM
4a. Facility Name (If not institution, give street and number): CARROLL CO. HOSPITAL
4b. City, Town, or Location of Death: WESTMINSTER
4c. County of Death: CARROLL

Funeral Director

5. Social Security Number: 213 34 6654
6. Sex: 1 X M 2 F
7. Age (In yrs. last birthday): 63 Yrs.
If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 12/4/37
9. Birthplace (State or Foreign Country): MD.

Usual Residence of Decedent

10a. State: MD.
10b. County: CARROLL
10c. City, Town or Location: ELDERBURG
10d. Inside City Limits: 1 X Yes 2 No
10e. Street and Number: 5201 EQUESTRAIN DR.
10f. Zip Code: 21784
10g. Citizen of What Country?: USA

11. Marital Status: 1 Never Married 2 Married 3 Widowed 4 X Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 X No If Yes, Give Year or Dates: X
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 X No Specify: X
14. Race - American Indian, Black, White, etc. Specify: AFRO AMERICAN

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4or 5+): 0
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): MECHANIC
18b. Kind of Business/Industry: SELF EMPLOYED

17. Father's Name (First, Middle, Last): OLIVER SLAUGHTER SR.
18. Mother's Name (First, Middle, Maiden Surname): LESSIE MOODY

19a. Informant's Name/Relationship (Type, Print): DR. H.D. SLAUGHTER(SON)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 10 CASSANDRA DR. RANDALLSTOWN, MD. 21133

20a. Method of Disposition: 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): WOODLAWN CEM. Date: 3/30/01
20c. Location - City or Town, State: WOODLAWN, MD.

21. Signature of Funeral Service Licensee: Paul A Estep
22. Name and Address of Facility: ESTEP BROTHERS FUNERAL SER, P.A. 1300 EUTAW PL. BALTO. MD. 21217

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Metastatic small cell lung cancer.
Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. Pleural effusion of right lung.
Due to (or as a consequence of):
c. Coronary artery disease
Due to (or as a consequence of):
d.

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown
23c. If yes, outcome of pregnancy: 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify) 9 Unknown
23d. Data of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 ✓ Yes 2 No 3 Probably 4 Unknown
24a. Was an autopsy performed? 1 Yes 2 No
24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No

25. Was case referred to medical examiner? 1 Yes 2 ✓ No
28. Place of Death (Check only one): Hospital: 1 ✓ Inpatient 2 ER/Outpatient 3 DOA; Other: 4 Nursing Home 5 Residence 6 Other (Specify)
27. Manner of Death: 1 ✓ Natural 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 Yes 2 No
26d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ✓ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner es steted. 2 **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the ceuse(s) and menner stated.
29b. Signature and title of certifier: Sharon Taylor-Hollihan
29c. License number: D51072
29d. Date signed (Month, Day, Year): 3/26/01
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Sharon Taylor-Hollihan Carroll County Hospital, Westminster, MD

State Registrar

31. Date filed (Month, Day, Year): APR 0 2 2001
32. Registrar's Signature: Donna G Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 28e or 28e-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

Medical Certification;

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 10017

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): JACQUELINE SCOTT

2. Date of Death: Month 3 Day 27 Year 2001

3. Time of Death: 5:35 pm

4a Facility Name (If not institution, give street and number): University of MARYLAND MEDICAL CENTER

4b. City, Town, or Location of Death: BALTIMORE

4c. County of Death:

Funeral Director

5. Social Security Number: 216-42-3563

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 57 Yrs. If Under 1 Year: Months / Days. If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): 01-10-1944

9. Birthplace (State or Foreign Country): MD

Usual Residence of Decedent

10a. State: MD

10b. County:

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 4111 Groveland Avenue

10f. Zip Code: 21215

10g. Citizen of What Country? USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12th grade; College (1-4or 5+): 2yrs.

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Secretary

16b. Kind of Business/Industry: Social Security Of.

17. Father's Name (First, Middle, Last): Isiah Dixon

18. Mother's Name (First, Middle, Maiden Surname): Mildred Waters

19a. Informant's Name/Relationship (Type, Print): Garrett Scott -Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4111 Groveland Avenue Baltimore, MD 21215

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, cremetory or other place): Woodlawn Cemetery

Date: 4-3-01

20c. Location - City or Town, State: Baltimore Co., Md

21. Signature of Funeral Service Licensee: ▶ Willis Edmond

22. Name and Address of Facility: March F/H West 4300 Wabash Ave, Baltimore, Md 21215

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. DILATED CARDIOMYOPATHY EF <20

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☐ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☐ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☐ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated. 2☐ Medical Examiner: On the besis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Felicia N Glenn MD.

29c. License number: P14672

29d. Date signed (Month, Day, Year): March 27, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): University Hospital 22 S. GREENE ST, Felicia Glenn MD

State Registrar

31. Date filed (Month, Day, Year): APR 0 2 2001

32. Registrar's Signature: ▶ Geneva B Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

01-1662-005
jhm
DAVID
SANCHEZ

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

1- For State Registrar AMEND ITEM 23a,b,ptII,28a-f per ME G796 060401 SS

Reg. No. 2001 10018

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
David F. Sanchez	MARCH 25, 2001	09:39A M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
6903 DUNMAN WAY APARTMENT 2-C	Dundalk	BALTIMORE

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
219-80-4597	1☒M 2☐F	40 Yrs.			04/23/1960	MD

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	Baltimore	Dundalk	1☐Yes 2☒No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
6903 Dunman Way APT 2-C	21222	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☒Never Married 2☐Married 3☐Widowed 4☐Divorced	1☐Yes 2☒No If Yes, Give Year or Dates:	1☒Yes 2☐No Specify: Spanish	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondery (0-12)	College (1-4or 5+)		
10		Bundler	Sparrows Point

17. Father's Name (First, Middle, Last)	18. Mother's Neme (First, Middle, Meiden Surname)
Juan Sanchez	Lorraine Sigai

19a. Informant's Name/Reletionship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code)
Juan Sanchez - Father	3415 Sollers Point RD Dundalk, MD 21222

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☐Burial 2☒Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	Balto-Wash. Crematory	03/29/01	Laurel, Maryland

21. Signature of Funeral Service Licensee ▶ [signature]

22. Name and Address of Facility
Bradley Ashton Matthews Funeral Home, Inc.
2134 Willow Spring Rd Baltimore, MD 21222

Physician /Medical Examiner

Medical Certification; To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heert failure. List only one cause on each line. GASTROINTESTINAL HEMORRHAGE AND NARCOTIC INTOXICATION

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Gastrointestinal Hemorrhage

Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
b. Chronic Alcoholism
Due to (or as a consequenca of):
c.
Due to (or as a consequence of):
d.

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐Yes 2☐No 9☐Unknown

23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) _____ 9☐Unknown

23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
CHRONIC ALCOHOLISM

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

24e. Was an autopsy performed? 1☒Yes 2☐No

24b. Were autopsy findings available prior to completion of cause of death? 1☒Yes 2☐No

25. Was case referred to medical examiner? 1☒Yes 2☐No

26. Place of Death (Check only one)
Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA
Other: 4☐Nursing Home 5☐Residence 6☒Other (Specify) SCENE

27. Manner of Death 1~~☒Natural~~ 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☒Could not be determined

28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
3-25-01	unknown M	1☐Yes 2☒No	unknown

28e. Place of Injury - At home, farm, street, factory, offica building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, Stete)
home	6903 Dunmanway, Baltimore, MD

29a. Certifier (Check only one) 1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end manner es stated. 2☒ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ [signature]	OCME	MARCH 26, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
J. Alan Lake, MD 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
APR 2 2001	▶ [signature] G. Sparks

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 10019

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Donald F Smith
2. Date of Death (Month, Day, Year): March 30 2001
3. Time of Death: 01:01 AM
4a. Facility Name (If not institution, give street and number): Baltimore VA Medical Center
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 218-09-0649
6. Sex: 1 ☒ M 2 ☐ F
7. Age (In yrs. last birthday): 79 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): April 23, 1921
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: MD
10b. County: Baltimore
10c. City, Town or Location: Catonsville
10d. Inside City Limits: 1 ☐ Yes 2 ☒ No
10e. Street and Number: 212 Montrose Avenue
10f. Zip Code: 21228
10g. Citizen of What Country?: United States

11. Marital Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☒ Yes 2 ☐ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 ☐ Yes 2 ☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondery (0-12): 12 | College (1-4or 5+):
16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired): Truck Driver
16b. Kind of Business/Industry: Trucking Company

17. Father's Name (First, Middle, Last): Harry T. Smith
18. Mother's Name (First, Middle, Maiden Surname): Elizabeth Barner

19a. Informant's Name/Relationship (Type, Print): Lynn Woodruff Niece
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1905 Windrow Court Marriottsville, MD 21104

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): MD Vet. Cem. Garrison For. Date: 4/4/01
20c. Location - City or Town, State: Baltimore, MD

21. Signature of Funeral Service Licensee: ▶
22. Name and Address of Facility: Sterling Ashton Schwab Funeral Home, Inc. 736 Edmondson Avenue Catonsville, MD 21228

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one ceuse on eech line. Approximate Interval Between Onset end Death

Immediate Cause (Final disease or condition resulting in death): a. Ventricular fibrillation — 1 hour
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☑ Yes 2 ☐ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☑ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No
26. Place of Death (Check only one): Hospital: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. Manner of Death: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☑ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred et the time, date end place, end due to the ceuse(s) and manner stated.
29b. Signature and title of certifier: ▶ Pamela H. Nagy
29c. License number: P136616
29d. Date signed (Month, Day, Year): March 30, 2001
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Pamela H. Nagy BVAMC 101 N. Greene St Baltimore MD 21201

State Registrar

31. Date filed (Month, Day, Year): APR 2 2001
32. Registrar's Signature: ▶ Geneva G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 10020

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): John J. Scales, Jr.

2. Date of Death (Month, Day, Year): March 27, 2001

3. Time of Death: 11:30 PM

4a. Facility Name (If not institution, give street and number): Keswick Nursing Home

4b. City, Town, or Location of Death: Baltimore City

4c. County of Death: N/A

Funeral Director

5. Social Security Number: 213-09-9757

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 85 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Sept. 26, 1915

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: N/A

10c. City, Town or Location: Baltimore City

10d. Inside City Limits: 1 [X] Yes 2 [ ] No

10e. Street and Number: 4207 Parkwood Avenue

10f. Zip Code: 21206

10g. Citizen of What Country? U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: WW II

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4 or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Police Officer

16b. Kind of Business/Industry: Baltimore City Police

17. Father's Name (First, Middle, Last): John J. Scales, Sr.

18. Mother's Name (First, Middle, Maiden Surname): Jessie E. Meyers

19a. Informant's Name/Relationship (Type, Print): James J. Scales - Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2603 Kentucky Avenue Baltimore, MD 21213

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Moreland Memorial

Date: 3/31/01

20c. Location - City or Town, State: Baltimore, MD

21. Signature of Funeral Service Licensee: Paul L Hartbrock Jr

22. Name and Address of Facility: Leonard J. Ruck, Inc. 5305 Harford Rd. Baltimore, MD 21214

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. progressive dementia with

Due to (or as a consequence of):

b. oral-pharyngeal dysphagia — years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Coronary Artery Disease

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [X] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

29e. Certifier (Check only one): 1 [X] Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: W. Anthony Riley, MD

29c. License number: D25205

29d. Date signed (Month, Day, Year): March 29, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): W. A. Riley GBMC 6701 N. Charles St Balto. md 21204

State Registrar

31. Date Filed (Month, Day, Year): APR 02 2001

32. Registrar's Signature: D Sparks

DHMH 16 Rev 6/95

ORIGINAL

John Scales March 27, 2001 11:30 P.M.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

1- For State Registrar

Reg. No. 2001 10021

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Daath
DORIS SWEARINGEN	March 27, 2001	3:14 PM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Johns Hopkins Bayview Medical Ctr.	Baltimore City	N/A

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
217-18-0319	1☐M 2☒F	76 Yrs.			April 9,1924	Maryland

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Baltimore	Dundalk	1☐Yes 2☒No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
7813 Kentley Road	21222	United States

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedant of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐Never Married 2☒Married 3☐Widowed 4☐Divorced	1☐Yes 2☒No If Yes, Give Year or Dates:	1☐Yes 2☒No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
10 Years		Salesperson	Retail

17. Father's Name (First, Middle, Last)	18. Mothar's Name (First, Middle, Maiden Surname)
Joseph Rayman	Daisy Kolbe

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Mr. John A. Swearingen (Husband)	7813 Kentley Road Dundalk, Maryland 21222

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or othar place)	Date	20c. Location - City or Town, State
1☒Burial 2☐Cremation 3☐Removal from Stata 4☐Donation 5☐Other (Specify)	Oak Lawn Cemetery	2/31/2001	Baltimore, Maryland

21. Signature of Funeral Service Licensee	22. Nama and Address of Facility
Stephanie Massey	Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused tha death. Do not enter tha moda of dying, such as cerdiac or raspiratory arrast, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. CORONARY ARTERY DISEASE

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b. HYPERTENSION

Dua to (or as a consequence of):

c. Due to (or as a consequence of):

d.

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1☐Yes 2☒No 9☐Unknown	23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of daath 5☐Othar (specify) 9☐Unknown	23d. Date of dalivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobecco use contribute to the cause of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

24a. Was an autopsy performed? 1☐Yes 2☒No	24b. Were autopsy findings available prior to completion of cause of death? 1☐Yas 2☐No

25. Was case referred to medical examiner? 1☐Yes 2☒No	26. Place of Death (Check only one) Hospital: 1☐Inpatient 2☒ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined	28a. Data of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? 1☐Yes 2☐No	28d. Describe how injury occurred
	28a. Place of Injury - At homa, farm, street, factory, office building, etc. (Specify)			28f. Location (Streat and Number or Rural Routa Number, City or Town, State)

Medical Certification; To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and dua to the cause(s) and manner as stated. 2☐**Medical Examiner:** On tha basis of axamination and/or investigation, in my opinion, death occurred at the tima, data and place, and dua to tha cause(s) and mannar stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
MD	D53534	MARCH 28, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): ROBERT CONNORS 1792 MERRITT BOULEVARD BALTIMORE, MD 21222

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
APR 2 2001	

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To be Completed by Funeral Director

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked othar than 'natural', or Items 23a or 28a-f show any injury or othar traumatic avent, the Medical Examiner must be notified at once.**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by tha funeral director, page 2 should be detached for use as the burial-transit

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 10022

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
Ressie Virginia Shiflett	March 28, 2001	1:10 AM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Eastpoint Nursing Home	Eastpoint	Baltimore

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
214-20-4355	1☐M 2☒F	87 Yrs.			June 6, 1913	Virginia

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Baltimore	Dundalk	1☐Yes 2☒No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
2606 West Woodwell Road	21222	United States

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐Never Married 2☒Married 3☐Widowed 4☐Divorced	1☐Yes 2☒No If Yes, Give Year or Dates:	1☐Yes 2☒No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
10 Years		Homemaker	Own Home

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Not Known Morris	Louisa Morris

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Husband Mr. William E. Shiflett	2606 West Woodwell Road Dundalk, Maryland 21222

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒Burial 2☐Cremation 3☐Removet from State 4☐Donation 5☐Other (Specify)	Holly Hill Mem. Gdns.	3/31/2001	Middle River, MD

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ Gregory E. Reed	Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222

Physician /Medical Examiner

Medical Certification; To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. DEMENTIA	2 YRS
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of):	
	c. Due to (or as a consequence of):	
	d. Due to (or as a consequence of):	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month Day Year
1☐Yes 2☒No 9☐Unknown	1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnent at time of death 5☐Other (specify) 9☐Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

PRESSURE SORE

23e. Did tobacco use contribute to the cause of death?	24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐Yes 2☒No 3☐Probably 4☐Unknown	1☐Yes 2☒No	1☐Yes 2☒No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐Yes 2☒No	Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA	Other: 4☒Nursing Home 5☐Residence 8☐Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined		M	1☐Yes 2☐No	
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ Matthew McNulty MD	D45757	MARCH 28, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
MATT McNABNEY 5505 HOPKINS BAYVIEW CIRCLE BALT 21224

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
APR 2 2001	▶ Jeanne B. Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23e or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 10023

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
Lee Truesdale	March 11 2001	2115 M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Southern Maryland Hospital	Clinton	Prince Georges

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
247-44-6702A	XX 1 M 2 F	79 Yrs.			9/17/21	Kershaw Co, SC

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
D C		Washington	XX 1 Yes 2 No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
4008 7th Street, NW	20011	U. S. A.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Rece - American Indien, Bleck, White, etc.
XX 1 Never Married 2 Married 3 Widowed 4 Divorced	XX 1 Yes 2 No If Yes, Give Year or Dates: 2/3/45	1 Yes 2 XX No Specify:	Specify: Black

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	18b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12th		Transportation Driver	Private

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Sumame)
Robert Truesdale	Sallie Truesdale

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Linda Truesdale/great-great niece	4008 7th Street, NW Wash., DC 20011

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
XX 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)	Quantico National Cem	3/15/01	Quantico, Va.

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
John Latney CC0348	Latney's Funeral Home Inc. 3831 Georgia Avenue, NW Wash., DC 20011

Physician /Medical Examiner

Medical Certification; To Be Completed by Physician/Medical Examiner

23a. Part1. Enter the diseese, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset end Death

Immediate Cause (Final diseese or condition resulting in death)

a. SEPTICEMIA

Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Diseese or injury thet initiated events resulting in death) Last

Due lo (or as e consequence of):

b. ASPIRATION PNEUMONIA

Due to (or as a consequence of):

c.

Due to (or es e consequence of):

d.

IF FEMALE:

23b. Wes decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown

23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant et time of deeth 5 Other (specify) 9 Unknown

23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing lo deeth but not resulting in the underlying cause given in Part I.

SIGMOID COLON VOLVULUS

23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 XX Unknown

24a. Was an autopsy performed? 1 Yes 2 XX No

24b. Were eulopsy findings available prior to completion of cause of death? 1 Yes 2 XX No

25. Was case referred to medical exeminer? 1 Yes 2 XX No

28. Place of Deeth (Check only one)

Hospital: 1 XX Inpatient 2 ER/Outpatient 3 DOA

Other: 4 Nursing Home 5 Residence 8 Other (Specify)

27. Menner of Deeth 1 XX Natural 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury et Work? 1 Yes 2 No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street end Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1 XX **Certifying Physician**: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated. 2 **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, dete and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Yeer)
MD	D53885	3/12/01

30. Name and address of person who completed cause of deeth (Item 23e) (Type, Print) VENKAT S RAMAVAN 7501 SURRATTS ROAD #307 CLINTON MD 20735

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
APR 0 2 2001	Geneva G Sparks

DHMH 17 Rev 1/2001

ORIGINAL

To the Hospital or Attending Physician: The law requires that the death certificate be axecuted within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use es the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other treumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

Expired 03-11-01 @ 2115

Dr Ramanan

Truesdale, Lee

4

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 10024

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: AMELIA TAYLOR
2. Date of Death Month / Day / Year: MARCH 27 2001
3. Time of Death: 0805 AM
4a. Facility Name *(If not institution, give street and number)*: The Johns Hopkins Hospital
4b. City, Town, or Location of Death: Baltimore City
4c. County of Death:

Funeral Director

5. Social Security Number: 216-42-3322
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 58 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: 01-09-1943
9. Birthplace *(State or Foreign Country)*: NY

Usual Residence of Decedent

10a. State: MD
10b. County: NA
10c. City, Town or Location: Baltimore
10d. Inside City Limits: ☒ Yes 2☐ No
10e. Street and Number: 257 S. Ballon Court
10f. Zip Code: 21231
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No — If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* Black

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12th grade — College (1-4 or 5+): N/A
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Seamstress
16b. Kind of Business/Industry: Self Employed

17. Father's Name *(First, Middle, Last)*: Unknown
18. Mother's Name *(First, Middle, Maiden Surname)*: Mary Frances Bell

19a. Informant's Name/Relationship *(Type, Print)*: Brian Sykes-Son
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 3923 Bonner Road Baltimore, MD

20a. Method of Disposition: ☒ 1 Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory, or other place)*: King Memorial Park
Date: 4/3/01
20c. Location - City or Town, State: Randallstown, MD

21. Signature of Funeral Service Licensee: William Edmonds
22. Name and Address of Facility: March Funeral Home, West 4300 Wabash Avenue, Balt. MD 21215

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. VENO THROMBOEMBOLIC DISEASE — 15 months
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
END STAGE RENAL DISEASE
CORONARY ARTERY DISEASE

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day, Year)*
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28a. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: MD
29c. License number: RES-000
29d. Date signed *(Month, Day, Year)*: March 27, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): BENJAMIN S. HERMAN, MD 600 NORTH WOLFE STREET, BALTIMORE MD 21287

State Registrar

31. Date filed *(Month, Day, Year)*: APR 0 2 2001
32. Registrar's Signature: Penny D Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 10025

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Helena Tillery

2. Date of Death: Month 3 Day 28 Year 2001

3. Time of Death: 1010 am

4a. Facility Name (If not institution, give street and number): Genesis Long Green Pavilion

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: Baltimore City

Funeral Director

5. Social Security Number: 214-16-3902

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 79 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): 4/19/21

9. Birthplace (State or Foreign Country): NC

Usual Residence of Decedent

10a. State: MD

10b. County: NA

10c. City, Town or Location: ~~Mexico~~ Baltimore

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 18 North Monroe Street

10f. Zip Code: 21223

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 9th grade; College (1-4 or 5+): N/A

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): House Management

16b. Kind of Business/Industry: Howard Head Corp.

17. Father's Name (First, Middle, Last): Willie Sharrock

18. Mother's Name (First, Middle, Maiden Surname): Bessie Sharrock

19a. Informant's Name/Relationship (Type, Print): Marchelle R. Simpson-Daug.

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1838 W. Fairmont Ave. Balt. MD 21223

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Arbutus Cemetery

Date: 4-2-01

20c. Location - City or Town, State: Arbutus, MD

21. Signature of Funeral Service Licensee: Willie Edmond

22. Name and Address of Facility: March Funeral Home/West, 4300 Wabash Avenue, Baltimore, MD 21215

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Stroke — hours

Due to (or as a consequence of):

b. Arteriosclerotic Cerebrovascular Disease — years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Dementia

Breast Cancer

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier:

29c. License number: D17118

29d. Date signed (Month, Day, Year): Mar 28, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Paul Schwartz MD 7700 York Rd 21204

State Registrar

31. Date filed (Month, Day, Year): APR 0 2 2001

32. Registrar's Signature: Geneva G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 10026

Physician /Medical Examiner

1. Decedent's Neme *(First, Middle, Last)*: Charles G. Triplett

2. Date of Death — Month: March Dey: 28, Year: 2001

3. Time of Death: 6:30 a.m.

4a. Facility Neme *(If not institution, give street end number)*: Stella Maris

4b. City, Town, or Location of Death: Timonium

4c. County of Death: Baltimore Co.

Funeral Director

5. Social Security Number: 219-18-3802

6. Sex: 1 [X] M 2 [ ] F

7. Age *(In yrs. lest birthdey)*: 76 Yrs. — If Under 1 Year: Months / Deys; If Under 24 Hrs.: Hours / Min.

8. Dete of Birth *(Month, Day, Year)*: Jan. 4, 1925

9. Birthplace *(Stete or Foreign Country)*: Maryland

Usuet Residence of Decedent

10a. Stete: Maryland

10b. County: Baltimore Co.

10c. City, Town or Location: Reisterstown

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 3414 Buttonwood Court

10f. Zip Code: 21136

10g. Citizen of Whet Country?: United States

11. Meritel Status: 1 [ ] Never Merried 2 [ ] Merried 3 [X] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U,S. Armed Forces? 1 [X] Yes 2 [ ] No — If Yes, Give Year or Detes: WWII

13. Wes Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.): 1 [ ] Yes 2 [X] No *Specify:*

14. Race - American Indian, Bleck, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementery/Secondery (0-12): 12 Yrs. / College (1-4or 5+):

16a. Decedent's Usuel Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Branch Manager

16b. Kind of Business/Industry: Social Security

17. Father's Neme *(First, Middle, Last)*: Lawrence Triplett

18. Mother's Neme *(First, Middle, Maiden Surname)*: Martha Bagent

19a. Informant's Neme/Retetionship *(Type, Print)*: Mr. Lawrence Triplett / son

19b. Meiling Address *(Street end Number or Rural Route Number, City or Town, Stete, Zip Code)*: 3414 Buttonwood Court Reisterstown, Maryland 21136

20a. Method ot Disposition: 1 [ ] Burial 2 [ ] Cremetion 3 [ ] Removet from Stete 4 [ ] Donetion 5 [X] Other *(Specify)* Entombment

20b. Piece ot Disposition *(Neme of cemetery, cremetory or other piece)*: Parkwood Cemetery

Dete: 3/30/2001

20c. Location - City or Town, Stete: Baltimore, Maryland

21. Signeture of Funeral Service Licensee: Michael E. Canapp

22. Neme end Address ot Fecility: LEONARD J. RUCK, INC. 5305 Harford Road Baltimore, MD 21214

Physician /Medical Examiner

23a. Part1. Enter the diseese, or complicetions that caused the deeth. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heert teilure. List only one ceuse on eech line.

Approximete Interval Between Onset and Death

Immediete Cause (Finet diseese or condition resulting in deeth)

a. PNEUMONIA

Due to (or es a consequence of):

Sequentially list conditions, if any, leeding to immediete cause. Enter Underlying Cause (Diseese or Injury that initieted events resulting in deeth) Last

b.

Due to (or es a consequence of):

c.

Due to (or es a consequence of):

d.

Pert II. **Other significent conditions** contributing to deeth but not resulting in the underlying cause given in Pert I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24e. Wes en eutopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place ot Death *(Check only one)*: Hospitel: 1 [ ] Inpetient 2 [ ] ER/Outpetient 3 [ ] DOA — Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [X] Other *(Specify)* HOSPICE

27. Menner of Death: 1 [X] Netural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigetion 6 [ ] Could not be determined

28a. Dete ot Injury *(Month, Dey Yeer)*

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Piece ot Injury - At home, term, street, tactory, office building, etc. *(Specify)*

28f. Location *(Street end Number or Rural Route Number, City or Town, Stete)*

29a. Certifier *(Check only one)*: 1 [X] **Certifying Physician:** To the best of my knowledge, deeth occurred at the time, dete end plece, end due to the cause(s) and manner es stated. 2 [ ] **Medical Examiner:** On the basis of exemination end/or investigetion, in my opinion, death occurred et the time, date and plece, and due to the cause(s) end menner steted.

29b. Signeture end title of certifier:

29c. License number: D43725

29d. Date signed *(Month, Day, Year)*: 3/28/01

30. Neme and address of person who completed cause of deeth (Item 23a) (Type, Print): DR. TARIQ MAHMOOD 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093

State Registrar

31. Date filed *(Month, Day, Year)*: APR 0 2 2001

32. Registrer's Signeture: G Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 28a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

MARCH 28, 2001 6:30 a.m.

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Division of Vital Records, P.O. Box 68760,

CHARLES TRIPLETT

ADH
TERESA WASHINGTON
01-1654-033

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

1- For State Rsgistrar

Reg. No. 2001 10027

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)		2. Date of Death Month Day Year	3. Time of Death
Teresa	Washington	MARCH 24, 2001	1358 PM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
SOUTHERN MARYLAND HOSPITAL CENTER	CLINTON	PRINCE GEORGES

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
229-84-9401	1☐M 2☒F	43 Yrs.			Aug 23 1957	V.A.

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	Prince George	Captial Heights	1☐Yes 2☒No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
703 Clovis Ave	23074	U.S.A.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐Never Married 2☒Married 3☐Widowed 4☐Divorced	1☐Yes 2☒No If Yes, Give Year or Dates:	1☐Yes 2☒No Specify:	Specify: Black

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12th grade	2yrs	Laborer	General

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Russell Johnson	Gracie Jefferson

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
James Washington-Husband	703 Clovis Ave, 703 Clovis Ave Captial Heights 23074

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	Jefferson Memorial	3/31/01	Freeman, V.A.

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
Irene A. Thompson	March F/H West 4300 Wabash Ave, Baltimore, Md 21215

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Occlusive pulmonary thromboembolism	
	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Deep venous thrombosis of lower extremities	
	Due to (or as a consequence of):	
	c.	
	Due to (or as a consequence of):	
	d.	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month Day Year
1☐Yes 2☐No 9☒Unknown	1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown	

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

obesity

23e. Did tobacco use contribute to the cause of death?	24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐Yes 2☐No 3☐Probably 4☒Unknown	1☒Yes 2☐No	☒Yes 2☐No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)
1☒Yes 2☐No	Hospital: 1☐Inpatient 2☒ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined		M	1☐Yes 2☐No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

29a. Certifier (Check only one) 1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☒ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
Lloyd A Mudy, M.D.	OCME	MARCH 25, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Stephen S. Radentz 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
APR 0 2 2001	Brenda G Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 10028

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)		2. Date of Death Month	Day	Year	3. Time of Death
George E. Weicker, Jr.		April	1	2001	10:30 A.M.
4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death			
1227 Black Friars RD	Catonsville	Baltimore			

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
035-20-7380	1☒M 2☐F	69 Yrs.			07/01/1931	Washington D.C.

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	Baltimore	Catonsville	1☐Yes 2☒No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
1227 Black Friars RD	21228	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐Never Married 2☒Married 3☐Widowed 4☐Divorced	1☐Yes 2☒No If Yes, Give Year or Dates:	1☐Yes 2☒No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12	4	Industrial Engineer	Bethlehem Steel Corp.

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
George E. Weicker, Sr.	Louise Dawson

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Evelyn K. Weicker/Wife	1227 Black Friars RD Baltimore, MD 21228

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☐Burial 2☒Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	Balto-Wash. Crematory	04/03/2001	Laurel, Maryland

21. Signeture of Funeral Service Licensee	22. Name and Address of Facility
▶ Robert Bodach	Sterling Ashton Schwab Funeral Home, Inc. 736 Edmondson Ave. Baltimore, MD 21228

Physician /Medical Examiner

23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each fine.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Adenocarcinoma of the ampulla of Vater	20 months
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of):	
	c. Due to (or as a consequence of):	
	d. Due to (or as a consequence of):	

IF FEMALE: 23b. Was decedent pregnent in the past 12 months? 1☐Yes 2☐No 9☐Unknown	23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown	23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?	24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐Yes 2☐No 3☐Probably 4☒Unknown	1☐Yes 2☒No	1☐Yes 2☐No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐Yes 2☒No	Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA	Other: 4☐Nursing Home 5☒Residence 6☐Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined		M	1☐Yes 2☐No	
	28e. Place of Injury - At home, farm, street, factory, offica building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ Damian E Barbess MD	D 22114	April 2, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type. Print) DAMIAN E. BARBESS MD
5411 OLD FREDERICK RD., SUITE 18, BALTIMORE, MARYLAND 21229

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
APR 2 2001	Brenda G. Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 10029

AMND ITM# 8PER F.H. G794 4-4-2001 JAB

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): LOGAN MORRIS WILBURN

2. Date of Death (Month, Day, Year): MARCH 30 2001

3. Time of Death: 08:30 AM

4a. Facility Name (If not institution, give street and number): HARBOR HOSPITAL CENTER

4b. City, Town, or Location of Death: BALTIMORE

4c. County of Death: N/A

Funeral Director

5. Social Security Number: 240 26 2484

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 79 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Data of Birth (Month, Day, Year): MARCH 7, 1922

9. Birthplace (State or Foreign Country): Virginia

Usual Residence of Decedent

10a. State: MARYLAND

10b. County: Anne Arundel

10c. City, Town or Location: PASADENA

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 8090 ROUNDTABLE COURT

10f. Zip Code: 21122

10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: 1944-1945

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 11th grade; College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Carpenter

16b. Kind of Business/Industry: Construction

17. Father's Name (First, Middle, Last): Frank Wilburn

18. Mother's Name (First, Middle, Maiden Surname): Annie Satterwhite

19a. Informant's Name/Relationship (Type, Print): Marie M. Wilburn (Spouse)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 8090 Round Table Court, Pasadena, MD 21122

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetary, crematory or other place): Maryland Veterans Cemetery; Date: 4/3/01

20c. Location - City or Town, State: Crownsville, Maryland

21. Signature of Funeral Service Licensee: [signature]

22. Name and Address of Facility: Stallings Funeral Home, P.A. 3111 Mountain Road, Pasadena, MD 21122

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. MULTI ORGAN FAILURE — TWO WEEKS

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. LUNG CANCER (SMALL CELL) — THREE MONTHS

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [X] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature] M.D.

29c. License number: P13472

29d. Data signed (Month, Day, Year): MARCH 30, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): DR. SANDEEP GAUTAM, HARBOR HOSPITAL, BALTIMORE, MD-21225

State Registrar

31. Data filed (Month, Day, Year): APR 2 2001

32. Registrar's Signature: [signature]

ORIGINAL

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Physician or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 28a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 10030

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Amanda Warfield

2. Date of Death: Month March, Day 30, Year 2001

3. Time of Death: 2:40AM

4a. Facility Name *(If not institution, give street and number)*: Chesapeake Hospice House

4b. City, Town, or Location of Death: Linthicum

4c. County of Death: Anne Arundel

Funeral Director

5. Social Security Number: 216-12-0258

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 80 Yrs. — If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Feb. 2, 1921

9. Birthplace *(State or Foreign Country)*: Baltimore, MD

Usual Residence of Decedent

10a. State: Maryland

10b. County: Anne Arundel

10c. City, Town or Location: Pasadena

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 8497 Jenkins Road

10f. Zip Code: 21122

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12; College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Fiscal Account Supervisor

16b. Kind of Business/Industry: State of MD Dept. of Natural Resources

17. Father's Name *(First, Middle, Last)*: Joseph Jones

18. Mother's Name *(First, Middle, Maiden Surname)*: Mathilda Kirscher

19a. Informant's Name/Relationship *(Type, Print)*: Dorothy Brothers (Daughter)

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 8229 Reece Heights Drive, Severn, MD 21144

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Cedar Hill Cemetery

Date: April 2 2001

20c. Location - City or Town, State: Glen Burnie, Maryland

21. Signature of Funeral Service Licensee: ▶ Russell Stallings

22. Name and Address of Facility: Stallings Funeral Home, P.A. 3111 Mountain Road, Pasadena, MD 21122

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

e. CEREBROVASCULAR ACCIDENT — 4 DAYS

Due to (or as a consequence of):

b. METASTATIC BREAST CANCER — 1 YEAR

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☑ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☑ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ INTERNAL MEDICINE

29c. License number: D51104

29d. Date signed *(Month, Day, Year)*: MARCH 30, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): 4710 PENNINGTON AVENUE, BALTIMORE MD 21226

State Registrar

31. Date filed *(Month, Day, Year)*: APR 2 2001

32. Registrar's Signature: ▶ James G. Sparks

ORIGINAL

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 | 10031

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): WILLARD HENRY WOOD
2. Date of Death (Month Day Year): MARCH 29, 2001
3. Time of Death: 7:15PM
4a. Facility Name (If not institution, give street and number): KRIS-LEIGH ASSISTED LIVING
4b. City, Town, or Location of Death: GAMBRILLS
4c. County of Death: ANNE ARUNDEL

Funeral Director

5. Social Security Number: 010-22-6201
6. Sex: 1 ☒ M 2 ☐ F
7. Age (In yrs. last birthday): 95 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): MARCH 10, 1906
9. Birthplace (State or Foreign Country): PRINCE EDWARD ISLAND

Usual Residence of Decedent

10a. State: MD
10b. County: ANNE ARUNDEL
10c. City, Town or Location: CROFTON
10d. Inside City Limits: 1 ☐ Yes 2 ☒ No
10e. Street and Number: 1609 PARK RIDGE CIRCLE
10f. Zip Code: 21114
10g. Citizen of What Country?: USA

11. Marital Status: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementery/Secondery (0-12): 09 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): CLERK
16b. Kind of Business/Industry: RETAIL

17. Father's Name (First, Middle, Last): RICHARD HENRY WOOD
18. Mother's Name (First, Middle, Maiden Sumeme): DEBORAH LEA

19a. Informent's Name/Relationship (Type, Print): JOAN D. ROBBINS DAUGHTER
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1770 DRYDEN WAY CROFTON, MARYLAND 21114

20a. Method of Disposition: 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Piece of Disposition (Name of cemetery, crematory or other place): METRO CREMATORY
Date: 3-31-01
20c. Location - City or Town, State: BALTIMORE, MARYLAND

21. Signature of Funeral Service Licensee: Patrick J. Hardesty
22. Name and Address of Facility: HARDESTY FUNERAL HOME P.A. 851 ANNAPOLIS RD GAMBRILLS, MARYLAND 21054

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such es cardiac or respiratory errest, shock, or heert feiture. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediete Ceuse (Finai disease or condition resulting in death)
a. Alzheimer's Dementia — 5 years
Due to (or as e consequence of):

Sequentially list conditions, if any, teading to immediete cause. Enter Underlying Cause (Diseese or injury thet initiated events resulting in death) Last
b.
Due to (or es a consequence of):
c.
Due to (or es e consequence of):
d.

Part tt. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was en autopsy performed? 1 ☐ Yes 2 ☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☒ No

25. Was case refarred to medical examiner? 1 ☐ Yes 2 ☐ No
26. Place of Death (Check only one): Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify) ASSISTED LIVING

27. Menner of Death: 1 ☒ Netural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
28a. Date of Injury (Month, Dey Year)
28b. Time of Injury M
28c. Injury et Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, fectory, office buitding, etc. (Specify)
28f. Location (Street end Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) end menner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) and menner steted.
29b. Signature and title of certifier: MD
29c. License number: D 38958
29d. Date signed (Month, Day, Year): 3/30/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Dalgeet Singh Sidhu 1413 Annapolis Road #106 odenton 21113

State Registrar

31. Date filed (Month, Day, Year): APR 0 2 2001
32. Registrar's Signature: Geneva G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important:** If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 10032

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): EDWARD WRIGHT
2. Date of Death: Month MARCH Day 29 Year 2001
3. Time of Death: 1935
4a. Facility Name (If not institution, give street and number): JOHNS HOPKINS HOSPITAL
4b. City, Town, or Location of Death: Baltimore City
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 250-46-7260
6. Sex: 1 ☒ M 2 ☐ F
7. Age (In yrs. last birthday): 67 Yrs. If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 05-14-1933
9. Birthplace (State or Foreign Country): SC

Usual Residence of Decedent

10a. State: MD
10b. County: N/A
10c. City, Town or Location: BALTIMORE
10d. Inside City Limits: 1 ☒ Yes 2 ☐ No
10e. Street and Number: 2459 GRADIN AVE
10f. Zip Code: 21207
10g. Citizen of What Country: USA

11. Marital Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: BLACK

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): LONGSHOREMAN
16b. Kind of Business/Industry: TERMINAL OPERATION

17. Father's Name (First, Middle, Last): WILLIAM TORBIT
18. Mother's Name (First, Middle, Maiden Surname): ADA WRIGHT

19a. Informant's Name/Relationship (Type, Print): CEOLA WRIGHT, WIFE
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2459 GRADIN AVE, BALTO. MD 21207

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): WOODLAWN CEMETERY
Date: 04-3-01
20c. Location - City or Town, State: WOODLAWN, MD

21. Signature of Funeral Service Licensee: Willie E Howell Jr.
22. Name and Address of Facility: HOWELL FUNERAL HOME 4600 Liberty Hghts Ave, Balto. Md 21207

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death):
a. PNEUMONIA — 3days
Due to (or as a consequence of):
b. LYMPHOMA — 3 years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No
26. Place of Death (Check only one): Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA; Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
28a. Date of Injury (Month, Day, Year)
28b. Time of Injury
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: MD
29c. License number: RES 000
29d. Date signed (Month, Day, Year): MARCH 29 2001

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): SAPTARSI HALDAR 600 N WOLFE ST BALTIMORE, MD 21205

State Registrar

31. Date filed (Month, Day, Year): APR 2 2001
32. Registrar's Signature: Geneva G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 28a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

ADMEND ITEM: # 7, 9 PER F.H. G794 4-9-01 WR.

Certificate of Death

2001 10033
Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month	Day	Year	3. Time of Death
Mildred Harriet Waggoner	March	31	2001	0001

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Franklin Square Hospital Center	Rosedale	Baltimore

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year Months	If Under 1 Year Days	If Under 24 Hrs. Hours	If Under 24 Hrs. Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
196-20-5823	1☐M 2☒F	75 ~~79~~ Yrs.					Jan. 16, 1926 ~~1922~~	Maryland

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Baltimore	Essex	1☐Yes 2☒No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
1448 Kent Road	21221	U.S.A.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐Never Married 2☒Married 3☐Widowed 4☐Divorced	1☐Yes 2☒No If Yes, Give Year or Dates:	1☐Yes 2☒No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12		Computer Operator	Court House for Baltimore County

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Paul Johnson Wilson	Olive Carey Whitmeyer

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
George W. Waggoner (husband)	1448 Kent Road, Essex, Maryland 21221

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☐Burial 2☐Cremation 3☒Removal from State 4☐Donation 5☐Other (Specify)	Freemansburg United Cem.	4/4/2001	Westin, West Virginia

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
	Bruzdzinski Funeral Home, P.A. 1407 Old Eastern Avenue, Essex, Maryland 21221

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Renal failure	12 months
	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. nephrosclerosis	12 months
	Due to (or as a consequence of):	
	c. Hypertension	3½ months
	Due to (or as a consequence of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

metastatic ovarian cancer

23b. Did tobacco use contribute to the cause of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐Yes 2☒No	1☐Yes 2☐No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐Yes 2☐No	Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA	Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined		M	1☐Yes 2☐No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1☑**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
Jacqueline A Williams MD	D 192666	3/31/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr. Jacqueline, William 9000 franklin Square Drive Baltimore, Md 21237

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
APR 0 2 2001	Geneva G Sparks

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 28a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Waggoner Mildred
Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 16 Rev 6/95

ORIGINAL

01-1388-019
BETTY BEDSWORTH
JVW

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

amend item# 1 per FH 10a,10b,10c,10e,10f, 3/16/01bg

For State Registrar

Certificate of Death

2001 10034
Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
BETTY A. BEDSWORTH	MARCH 11, 2001	2:19 PM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
DOCHESTER GENERAL HOSPITAL	CAMBRIDGE	DORCHESTER

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
221-24-2260	1 M 2 X F	64 Yrs.			03-05-37	MARYLAND

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
DE ~~MD~~	Sussex ~~Somerset~~	~~Eden~~ Seaford	1 Yes 2 X No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
~~PO Box 174~~ PO Box 43B	19973 ~~21822~~	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1 Never Married 2 Married 3 X Widowed 4 Divorced	1 Yes 2 X No If Yes, Give Year or Dates:	1 Yes 2 X No Specify:	Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	18b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12	none	BOOKEEPER	ACCOUNTING

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
John Edwin Pote	Esther Sara Sigel

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
WILLIAM B. BEDSWORTH/ SON	P.O. BOX 174, EDEN, MD. 21822

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify)	SALISBURY CREMATORY	3/13/01	SALISBURY, MD.

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
James L Hinman MO0295	HINMAN FUNERAL HOME, P.A., PRINCESS ANNE, MD.

Physician /Medical Examiner

Medical Certification; To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Occlusive Pulmonary thromboembolism	
Due to (or as a consequence of):		
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Deep venous thrombosis of lower extremities	
Due to (or as a consequence of):		
	c.	
Due to (or as a consequence of):		
	d.	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month Day Year
1 Yes 2 X No 9 Unknown	1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify) 9 Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Hypertensive atherosclerotic Cardiovascular disease

23e. Did tobacco use contribute to the cause of death? 1 Yes 2 X No 3 Probably 4 Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1 X Yes 2 No	1 X Yes 2 No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1 X Yes 2 No	Hospital: 1 Inpatient 2 X ER/Outpatient 3 DOA	Other: 4 Nursing Home 5 Residence 6 Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1 X Natural 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined		M	1 Yes 2 No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 X **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
Stephen L Radentz, M.D.	O.C.M.E.	MARCH 12, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Stephen S. Radentz, 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
MAR 13 2001	Geneva G. Sparks

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than 'natural', or Items 23e or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 10035

IDA BAKER 218-24-4126

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Physician /Medical Examiner

Funeral Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last)			2. Date of Death Month Day Year	3. Time of Death
Delema	Ida	Baker	March 16, 2001	1830

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
PENINSULA REGIONAL MEDICAL CENTER	SALISBURY	WICOMICO

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
218-24-4126	1☐ M 2☒ F	77 Yrs.			08/09/1923	Delaware

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	Somerset	Princess Anne	1☒ Yes 2☐ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
Stewart Neck Apts, Nutters Lane	21853	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced	1☐ Yes 2☒ No If Yes, Give Year or Dates:	1☐ Yes 2☒ No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
2	none	Housekeeper	Domestic/Cleaning

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Elisha Baker	Birdie Mitchell

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Mary Ann Layfield/niece	12163 East Ridge Road, Princess Anne, Md. 21853

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)	Allen U.M. Cemetery	3/19/01	Allen, Maryland

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
James L Hinman M00295	Hinman Funeral Home Princess Anne, Md. 21853

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Renal Failure	
	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. CHF	
	Due to (or as a consequence of):	
	c.	
	Due to (or as a consequence of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐ Yes 2☒ No	1☐ Yes 2☐ No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐ Yes 2☒ No	Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA	Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined		M	1☐ Yes 2☐ No	
	28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)

29e. Certifier (Check only one)
1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
Nathan	D47094	3/18/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
NATHAN 106 PINE BLUFF ROAD SALISBURY MD 21801

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
MAR 21 2001	Jennie G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 10036

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Alice Freeman Beasley

2. Date of Death Month Dey Yaar: March 16, 2001

3. Time of Death: 8:00 am

4a. Facility Name *(If not institution, give street and number)*: 8280 Frances Lane

4b. City, Town, or Location of Death: Owings

4c. County of Death: Calvert

Funeral Director

5. Social Security Number: 239 54 0018

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 65 Yrs.

If Under 1 Yaar: Months / Deys

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Jan 28, 1936

9. Birthplace *(State or Foraign Country)*: NC

Usual Residenca of Decedent

10a. Stete: MD

10b. County: Calvert

10c. City, Town or Location: Owings

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 8280 Frances Lane

10f. Zip Code: 20736

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Wes Decedent Ever in U.S. Armed Forcas? 1☐ Yes 2☒ No If Yes, Give Yaar or Datas:

13. Was Decedent of Hispanic Origin? (Specify Yas or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Bleck, Whita, atc. *Specify:* white

15. Decedent's Education *(Specify only highast grada completad)*: Elementery/Secondery (0-12): 12 / College (1-4or 5+):

16a. Decedent's Usuel Occupation *(Giva kind of work dona during most of working life. DO NOT usa retired)*: housewife

16b. Kind of Business/Industry: own home

17. Father's Neme *(First, Middla, Last)*: Miles Lawrence Vinson

18. Mother's Neme *(First, Middla, Maidan Sumama)*: Essie Freeman Faircloth

19a. Informant's Neme/Reletionship *(Type, Print)*: Richard Beasley (husb.)

19b. Mailing Address *(Straat and Number or Rural Routa Number, City or Town, State, Zip Code)*: same as 10a-f above

20a. Method of Disposition: 1☐ Burial 2☒ Cramation 3☐ Ramoval from Stata 4☐ Donetion 5☐ Other *(Specify)*

20b. Plece of Disposition *(Nama of camatary, cramatory or othar place)*: Metropolitan Crematory

Dete: 3-18-01

20c. Location - City or Town, State: Alexandria, VA

21. Signature of Funeral Service Licensee ▶ [signature]

22. Neme end Addrass of Facility: Rausch Funeral Home, Owings, MD 20736

Physician /Medical Examiner

23a. Part1. Enter the diseesa, or complications thet caused tha daath. Do not anter tha mode of dying, such es cardiec or respiretory errest, shock, or heert feilure. List only one ceuse on eech line.

Approximate Intervel Between Onset and Death

Immediete Cause (Final diseese or condition resulting in death): e. End stage Parkinson's Disease — ~5 years

Due to (or as e consequence of):

Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initieted avents resulting in death) Last

b. Due to (or as e consequenca of):

c. Due to (or es e consequence of):

d.

Part II. **Other significant conditions** contributing to death but not rasulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Wes en eutopsy performed? 1☒ Yes 2☐ No

24b. Were eutopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Wes case referred to medical exeminer? 1☒ Yes 2☐ No

26. Place of Death *(Chack only one)*: Hospitel: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☒ Residenca 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Naturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined

28a. Dete of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury et Work? 1☐ Yes 2☐ No

28d. Dascribe how injury occurred

28e. Plece of Injury - At home, farm, street, fectory, offica building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Routa Number, City or Town, Stata)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, deeth occurred at the time, dete end plece, end due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On tha basis of axamination and/or invastigetion, in my opinion, deeth occurred at the time, dete and plece, and due to the ceuse(s) and mannar stated.

29b. Signeture and title of certifier ▶ [signature] Catherine Brophy MD

29c. License number: D45235

29d. Date signed *(Month, Day, Year)*: 3/16/01

30. Neme and address of person who completed cause of death (Item 23a) (Type, Print): Catherine Brophy, MD Dunkirk, MD 20754

State Registrar

31. Date filed *(Month, Day, Year)*: MAR 19 2001

32. Registrer's Signeture ▶ Geneva G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 10037

Nara · campbell

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: NORA MAY CAMPBELL
2. Date of Death Month: MARCH Day: 4th Year: 2001
3. Time of Death: 2:45 PM
4a. Facility Name *(If not institution, give street and number)*: Western Maryland Hospital Center
4b. City, Town, or Location of Death: Hagerstown
4c. County of Death: Washington

Funeral Director

5. Social Security Number: 578-78-4504
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 70 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: Mar. 21, 1930
9. Birthplace *(State or Foreign Country)*: Jamaica

Usual Residence of Decedent

10a. State: Maryland
10b. County: Montgomery
10c. City, Town or Location: Takoma Park
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 7620 Maple Avenue #4
10f. Zip Code: 20912
10g. Citizen of What Country?: USA

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* African-American

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12) / College (1-4or 5+): 2
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Licensed practical nurse
16b. Kind of Business/Industry: Health Care

17. Father's Name *(First, Middle, Last)*: Unknown
18. Mother's Name *(First, Middle, Maiden Surname)*: Ima Jean Campbell

19a. Informant's Name/Relationship *(Type, Print)*: Winston Speid / Son
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 4 Taylor Street Providence, RI 02907

20a. Method of Disposition: 1☐ Burial 2☐ Cremation 3☐ Removal from State 4☒ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Howard U. Coll. of Med.
Date: 3/22/01
20c. Location - City or Town, State: Washington, DC

21. Signature of Funeral Service Licensee: ▶ Lori V. Lincoln
22. Name and Address of Facility: Lincoln & Lincoln Funeral Service, 4315 Anacostia Ave., NE Wash., DC 20019

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Sepsis — weeks
Due to (or as a consequence of):
b. Chronic Renal failure on Hemodialysis months

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c. Diabetes Mellitus
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
Hypertension
Coronary Artery Disease

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown
24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

Medical Certification: To Be Completed by Physician/Medical Examiner

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death *(Check only one)*: Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*
27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined
28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: ▶ Rene Marie Okaw, M.D.
29c. License number: D76416
29d. Date signed *(Month, Day, Year)*: March 20th, 2001
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): 1500 Pennsylvania Avenue, Hagerstown, MD 21742

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

State Registrar

31. Date filed *(Month, Day, Year)*: APR 0 2 2001
32. Registrar's Signature: ▶ Geneva G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 10038

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): THOMAS ALLEN DELANEY
2. Date of Death (Month, Day, Year): MARCH 17, 2001
3. Time of Death: 2235pm
4a. Facility Name (If not institution, give street and number): Calvert Memorial Hospital
4b. City, Town, or Location of Death: Prince Frederick
4c. County of Death: Calvert

Funeral Director

5. Social Security Number: 059-18-2412
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 81 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Nov. 19, 1919
9. Birthplace (State or Foreign Country): New York

Usual Residence of Decedent

10a. State: MD
10b. County: Calvert
10c. City, Town or Location: Prince Frederick
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 761 Dan Bowen Road
10f. Zip Code: 20678
10g. Citizen of What Country?: United States

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: 1941-1945
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4 or 5+): 4
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Agent
16b. Kind of Business/Industry: Federal Bureau of Investigation

17. Father's Name (First, Middle, Last): Edward Delaney
18. Mother's Name (First, Middle, Maiden Surname): Emily Hamilton

19a. Informant's Name/Relationship (Type, Print): Charlotte S. Delaney - Wife
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 761 Dan Bowen Rd. Prince Frederick, MD 20678

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Metropolitan Crematory
Date: Mar. 19, 2001
20c. Location - City or Town, State: Alexandria, Virginia

21. Signature of Funeral Service Licensee: MO1095
22. Name and Address of Facility: Rausch Funeral Home, P.A. 4405 Broomes Island Rd. Port Republic, MD 20676

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Uro Sepsis
Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. Diabetes
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No
26. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)
27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day, Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: Joseph Barth
29c. License number: D0052292
29d. Date signed (Month, Day, Year): 03/18/01
30. Name and address of person who completed cause of death (Item 23e) (Type, Print): JOESPH BARTH, MD 110 HOSPITAL RD. STE 310 PRINCE FREDERICK, MD 20678

State Registrar

31. Date filed (Month, Day, Year): MAR 19 2001
32. Registrar's Signature: Geneva B Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

12+1. graphs

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

REPLACEMENT

Certificate of Death

Reg. No. 2001-10039

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): ROBERT J. EDWARD

2. Date of Death (Month, Day, Year): MARCH 16, 2001

3. Time of Death: 10:00 AM

4a. Facility Name (If not institution, give street and number): 404 Fairhaven Court

4b. City, Town, or Location of Death: Federalsburg

4c. County of Death: Caroline

Funeral Director

5. Social Security Number: 252-42-2727

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 67 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): June 25, 1933

9. Birthplace (State or Foreign Country): unk

Usual Residence of Decedent

10a. State: MD

10b. County: Caroline

10c. City, Town or Location: Federalsburg

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 404 Fairhaven Manor

10f. Zip Code: 21632

10g. Citizen of What Country: USA

11. Marital Status: unk
1 [ ] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [ ] No unk
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc.
Specify: black

15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12): unk
College (1-4or 5+): unk

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): unk

16b. Kind of Business/Industry: unk

17. Father's Name (First, Middle, Last): unk

18. Mother's Name (First, Middle, Maiden Surname): unk

19a. Informant's Name/Relationship (Type, Print): Eskow Funeral Home

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): Box 43 Federalsburg, MD 21632

20a. Method of Disposition
1 [ ] Burial 2 [ ] Cremation 3 [ ] Removal from State
4 [ ] Donation 5 [X] Other (Specify): in state

20b. Place of Disposition (Name of cemetery, crematory or other place)

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee: Ronald S. Wade, Director

22. Name and Address of Facility: State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. myocardial infarction — 12 hrs

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

end stage renal disease managed by dialysis

hypertension

23b. Did tobacco use contribute to the cause of death?
1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one)
Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA
Other: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify)

27. Manner of Death
1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Lawrence D. Bohan

29c. License number: D 27409

29d. Date signed (Month, Day, Year): 3-20-01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Lawrence D. Bohan 505 Dutchmans Lane Easton, MD 21601

State Registrar

31. Date filed (Month, Day, Year): JUN 27 2001

32. Registrar's Signature: Geneva D Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than 'natural', or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 10040

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Omar L. Fulton, Sr.

2. Date of Death (Month, Day, Year): March 13 2001

3. Time of Death: 11:22pm

4a. Facility Name (If not institution, give street and number): Manokin Manor

4b. City, Town, or Location of Death: Princess Anne

4c. County of Death: Somerset

Funeral Director

5. Social Security Number: 221-07-6596

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 98 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): 03/03/1903

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Somerset

10c. City, Town or Location: Princess Anne

10d. Inside City Limits: 1 [X] Yes 2 [ ] No

10e. Street and Number: 11974 Edgehill Terrace

10f. Zip Code: 21853

10g. Citizen of What Country? USA

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 11

College (1-4or 5+): None

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Machinist

16b. Kind of Business/Industry: Electric

17. Father's Name (First, Middle, Last): Eugene Fulton

18. Mother's Name (First, Middle, Maiden Surname): Vermie Della Atkinson

19a. Informant's Name/Relationship (Type, Print): Elsie Cayaves/Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 310 Wyman Drive, Salisbury, Md. 21804

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Washington Cemetery

Date: 03/17/01

20c. Location - City or Town, State: Shad Point, MD

21. Signature of Funeral Service Licensee: James L. Hinman M00295

22. Name and Address of Facility: Hinman Funeral Home, 11673 Somerset Avenue, Princess Anne, Md. 21853

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
e. Aspiration Pneumonia

Due to (or as a consequence of):
b. CVA

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

28. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [X] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: N. Kirkin

29c. License number: D47094

29d. Date signed (Month, Day, Year): 3/15/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): NATHAN 106 PINE BLUFF ROAD SALISBURY MD 21801

State Registrar

31. Date filed (Month, Day, Year): MAR 16 2001

32. Registrar's Signature: Geneva G. Sparks

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Omar Fulton March 13, 2001 11:22 PM

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 10041

ATTN: Sheaise Smith

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Grace B Hildreth

2. Date of Death Month: 2 Day: 15 Year: 2001

3. Time of Death: 6:50 AM

4a. Facility Name *(If not institution, give street and number)*: Holly Hill Manor, Inc

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 212-05-1430

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 87 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: September 13, 1913

9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Md

10b. County: Baltimore

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: N Charles Street 3900

10f. Zip Code: 21218

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 / College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Housewife

16b. Kind of Business/Industry: Home

17. Father's Name *(First, Middle, Last)*: Frederick Burgess

18. Mother's Name *(First, Middle, Maiden Surname)*: Mary Elizabeth Schumann

19a. Informant's Name/Relationship *(Type, Print)*: Robert M Hildreth - Son

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 21012 West Liberty Road Whitehall md 21161

20a. Method of Disposition: 1☐ Burial 2☐ Cremation 3☐ Removal from State 4☒ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, cremetory or other place)*: Anatomical Gift Foundation — Date: 2-15-01

20c. Location - City or Town, State: Laurel Md

21. Signature of Funeral Service Licensee: ▶ B. C

22. Name and Address of Facility: Anatomical Gift Foundation 13948 Baltimore Ave Laurel md 20707

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than 'natural', or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Severe decompensated heart failure

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Arrythmias

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☑ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit.

29a. Certifier *(Check only one)*: 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Ashraf Salem Mostafa MD

29c. License number: D0053593

29d. Date signed *(Month, Day, Year)*: 3/07/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Ashraf Mostafa M.D. 7505 Osler Drive Towson, MD 21204

State Registrar

31. Date filed *(Month, Day, Year)*: APR 02 2001

32. Registrar's Signature: ▶ Geneva G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 10042

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)			2. Date of Death Month	Day	Year	3. Time of Death
John	R.	Holland	March	14	2001	10:15am

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Calvert County Nursing Center	Prince Frederick	Calvert

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
218-14-9670	1☒ M 2☐ F	86 Yrs.			April 4, 1914	Maryland

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Calvert	Huntingtown	1☐ Yes 2☒ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
3080 Hunting Creek Road	20639	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced	1☐ Yes 2☒ No If Yes, Give Year or Dates:	1☐ Yes 2☒ No Specify:	Specify: Black

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
8		Farmer	Farming

17. Father's Name (First, Middle, Last)		18. Mother's Name (First, Middle, Maiden Surname)	
James	Holland	Lillian	Green

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Helen Beverly/Daughter	7920 Main Falls Circle Baltimore, MD 21228

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)	Plum Point UM Chr. Cem.	3/19/01	Huntingtown, MD

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ Gladys G. Sewell	Sewell Funeral Home 1451 Dares Beach Rd. Prince Frederick, MD 20678

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Congestive Heart Failure	3years
	Due to (or as a consequence of): HTN	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	b.	
	Due to (or as a consequence of):	
	c.	
	Due to (or as a consequence of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Diabetes Type II

23b. Did tobacco use contribute to the cause of death? 1☒ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐ Yes 2☒ No	1☐ Yes 2☐ No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)
1☐ Yes 2☒ No	Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined		M	1☐ Yes 2☐ No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶	D59149	3/16/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DAVID GALLITAN, M.D Prince Frederick, MD

10

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
MAR 16 2001	▶ Geneva G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 28a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 10043

Physician /Medical Examiner

Funeral Director

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'natural', or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

1. Decedent's Name (First, Middle, Last)	2. Date of Death (Month, Day, Year)	3. Time of Death
Lottie Mae HOSE	March 12, 2001	12:50 a.M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Clearview Nursing Home	Hagerstown	Washington

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
219-30-5913	1☐M 2☒F	66 Yrs.			March 11, 1934	Maryland

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Washington	Williamsport	1☐Yes 2☒No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
12144 Kemps Mill Road	21795	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐Never Married 2☐Married 3☒Widowed 4☐Divorced	1☐Yes 2☒No If Yes, Give Year or Dates:	1☐Yes 2☒No Specify:	Specify: white

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
11	0	cook	children's home

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
George William Gifford	May Beal Saunders

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Fred Zybell - cousin	205 Walnut St., Point Marion, Pa. 15474

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☐Burial 2☒Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	Hagerstown Crematory	3/12/01	Hagerstown, Maryland

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ [signature]	MINNICH FUNERAL HOME 415 E. Wilson Blvd., Hagerstown, Md. 21740

Medical Certification: To Be Completed by Physician/Medical Examiner

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Carcinoma of ovary with metastases to	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of): b. Pelvis + Abdomen	1 year
	Due to (or as a consequence of): c.	
	Due to (or as a consequence of): d.	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery (Month, Day, Year)
1☐Yes 2☑No 9☐Unknown	1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Chronic pain due to metastases
Colostomy due to metastases

23e. Did tobacco use contribute to the cause of death?	24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐Yes 2☑No 3☐Probably 4☐Unknown	1☐Yes 2☑No	1☐Yes 2☐No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐Yes 2☑No	Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA	Other: 4☑Nursing Home 5☐Residence 8☐Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☑Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined		M	1☐Yes 2☐No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1☑**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ [signature]	D07857	03/12/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Edson Moody, M.D., 1190 Mt. Aetna Rd, Hagerstown, MD 21740

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
MAR 14 2001	[signature]

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Amend item 10a - per fh, 3/19/01, bg — For State Registrar — **Certificate of Death** — Reg. No. 2001 10044

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): LEONARD WASHINGTON JAMES JR.
2. Date of Death: Month MARCH Day 13 Year 2001
3. Time of Death: 0815 M
4a. Facility Name (If not institution, give street and number): PENINSULA REGIONAL MEDICAL CENTER
4b. City, Town, or Location of Death: SALISBURY
4c. County of Death: WICOMICO

Funeral Director

5. Social Security Number: 214-01-7935
6. Sex: 1 ☒ M 2 ☐ F
7. Age (In yrs. last birthday): 84 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 07-19-16
9. Birthplace (State or Foreign Country): MD

Usual Residence of Decedent

10a. State: MD
10b. County: SOMERSET
10c. City, Town or Location: PRINCESS ANNE
10d. Inside City Limits: 1 ☐ Yes 2 ☒ No
10e. Street and Number: 11551 PINE ~~KNOTT~~ POLE ROAD
10f. Zip Code: 21853
10g. Citizen of What Country? U.S.A

11. Marital Status: 1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 8th; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): LABORER
18b. Kind of Business/Industry: SHIP YARD

17. Father's Name (First, Middle, Last): Leonard W. James Sr.
18. Mother's Name (First, Middle, Maiden Surname): Addie CARR

19a. Informant's Name/Relationship (Type, Print): Hazel J. Mack - SISTER
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3001 Gwen Fall Parkway Baltimore MD 21216

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): John Wesley Cemetery
Date: 3-21-01
20c. Location - City or Town, State: Princess Anne, MD

21. Signature of Funeral Service Licensee: Anthony E. Ward Sr.
22. Name and Address of Facility: Anthony E. Ward Funeral Home 30639 Hampden Ave. Princess Anne, MD 21853

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. ACUTE ANTEROLATERAL MYOCARDIAL INFARCT — Approximate Interval Between Onset and Death: SIX HOURS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
b. CARDIOGENIC SHOCK. — SIX HOURS
Due to (or as a consequence of):
c. RENAL FAILURE — ONE WEEK
Due to (or as a consequence of):
d.

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown
23c. If yes, outcome of pregnancy: 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown
23d. Date of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No
28. Place of Death (Check only one): Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ATTENDING PHYSICIAN
29c. License number: D00460 29
29d. Date signed (Month, Day, Year): MARCH 13 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): ABDUL K. GARUBA, MD 12137 ELM ST., PRINCESS ANNE MD 21853

State Registrar

31. Date filed (Month, Day, Year): MAR 15 2001
32. Registrar's Signature: Geneva G. Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036
Division of Vital Records, P.O. Box 68760,

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 28a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Medical Certification; To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Leonard James 214-01-7935

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 10045

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): ALONZA S. LONG
2. Date of Death (Month, Day, Year): March 12, 2001
3. Time of Death: 7:47 AM
4a. Facility Name (If not institution, give street and number): E. W. McCready Memorial Hospital
4b. City, Town, or Location of Death: Crisfield
4c. County of Death: Somerset

Funeral Director

5. Social Security Number: 215-36-1023
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 82 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): May 3, 1918
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Somerset
10c. City, Town or Location: Marion Station
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 31834 Riverside Lane
10f. Zip Code: 21838
10g. Citizen of What Country? USA

11. Marital Status: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondery (0-12): 12
College (1-4or 5+):
16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired): Farmer
16b. Kind of Business/Industry: Farming

17. Father's Neme (First, Middle, Last): Alonza H. Long
18. Mother's Name (First, Middle, Maiden Surname): Lula Brittingham

19a. Informant's Neme/Relationship (Type, Print): R. Dorsey Long (brother)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code): 31834 Riverside Lane - Marion Station, MD 21838

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Piece of Disposition (Name of cemetery, crematory or other place): Rehobeth Baptist Cemetery
Date: 3/14/01
20c. Location - City or Town, State: Rehobeth, MD

21. Signeture of Funeral Service Licensee: Robert H. Bradshaw
22. Name and Address of Facility: Bradshaw & Sons Funeral Home 306 W. Main St. - Crisfield, MD 21817

Physician /Medical Examiner

23e. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Finai disease or condition resulting in deeth)
a. Pneumonia — days

Due to (or as a consequence of):
b. Renal Failure — days

Sequentielly list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last
c.
Due to (or as e consequenca of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Wes en autopsy pertormed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical exeminer? 1 [ ] Yes 2 [X] No

26. Piece of Death (Check only one)
Hospital: 1 [X] Inpatient 2 [ ] ER/Outpetient 3 [ ] DOA
Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Menner of Death: 1 [X] Netural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Piece of Injury - At home, farm, street, factory, offica building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician**: To the best of my knowledge, deeth occurred at the time, date end place, end due to the cause(s) and menner as stated. 2 [ ] **Medical Examiner**: On the basis of examination and/or investigation, in my opinton, deeth occurred at the time, dete and place, end due to the ceuse(s) and manner stated.

29b. Signeture and title of certifier: Madhav D. Barhan
29c. License number: 12764
29d. Date signed (Month, Day, Year): 3/13/01

30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print): Madhav D. Barhan, M.D. - 4384 Crisfield Highway - Crisfield, MD 21817

State Registrar

31. Date filed (Month, Day, Year): MAR 14 2001
32. Registrar's Signature: Geneva G. Sparks

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health end Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 10046

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Sidney Hugh Matthews

2. Date of Death (Month, Day, Year): March 15, 2001

3. Time of Death: 4:00 P.M.

4a. Facility Name (If not institution, give street and number): Solomons Nursing Center

4b. City, Town, or Location of Death: Solomons

4c. County of Death: Calvert

Funeral Director

5. Social Security Number: 577-28-0273

6. Sex: XX 1 M 2 F

7. Age (In yrs. last birthday): 78 Yrs.

If Under 1 Yaer: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Data of Birth (Month, Day, Year): April 7, 1922

9. Birthplace (State or Foreign Country): Virginia

Usual Residence of Dacedant

10a. State: MD

10b. County: Calvert

10c. City, Town or Location: Lusby

10d. Inside City Limits: 1 Yas 2 X No

10e. Street and Number: 900 Golden West Way

10f. Zip Coda: 20657

10g. Citizan of What Country?: United States

11. Merital Status: 1 Naver Merried 2 Married 3 Widowed 4 X Divorced

12. Wes Decedent Evar in U.S. Armed Forcas? XX Yas 2 No If Yas, Giva Yaar or Detes:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yas, specify Cuban, Mexican, Puerto Rican, atc.) 1 Yas 2 X No Specify:

14. Race - Amarican Indian, Black, White, atc. Specify: White

15. Decedant's Educetion (Specify only highest grade completed)

Elementary/Secondary (0-12): 12

Collega (1-4or 5+): -

16a. Decedent's Usual Occupation (Giva kind of work dona during most of working life. DO NOT use ratired): Transport Flight Crew Plane Captain

16b. Kind of Business/Industry: United States Navy

17. Fathar's Nama (First, Middle, Last): William H. Matthews

18. Mothar's Nama (First, Middle, Maidan Sumame): Marie Sheffield

19a. Informant's Name/Ralationship (Type, Print): Wm. Brent Matthews - Son

19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, Stata, Zip Code): 3137 Eutaw Forest Drive Waldorf, MD 20603

20a. Mathod of Disposition: XX Burial 2 Cremation 3 Removal from Stata 4 Donation 5 Othar (Specify)

20b. Place of Disposition (Nama of cemetary, crematory or othar place): MD Veterans' Cem. Cheltenham

Data: March 21, 2001

20c. Location - City or Town, State: Cheltenham, Maryland

21. Signatura of Funeral Service Licensee: MO 1095

22. Nama and Addrass of Facility: Rausch Funeral Home, P.A. 4405 Broomes Island Rd. Port Republic, MD 20676

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused tha daath. Do not antar tha moda of dying, such as cardiac or raspiratory arrest, shock, or heart failure. List only ona causa on aach lina.

Approximate Interval Batween Onsat and Death

Immediata Causa (Final disaasa or condition resulting in daath)

a. Cardiopulmonary ARREST

Dua to (or as a consequance of):

b. Congestive Heart Failure

Sequentially list conditions, if any, laading to immadiata ceusa. Entar Underlying Cause (Diseese or injury that initiated evants resulting in daath) Last

Due to (or as a consaquance of):

c. Cardiomyopathy

Due to (or as a consaquance of):

d. Anemia

Part II. **Other signficant conditions** contributing to death but not rasulting in tha underlying ceusa given in Part I.

Metastatic Rectal Cancer

Deubitis Ulcers

23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 X Probably 4 Unknown

24a. Was an autopsy performed? 1 Yas 2 X No

24b. Were autopsy findings available prior to completion of ceusa of death? 1 Yas 2 X No

25. Was cesa ratarred to medicat examinar? 1 Yas 2 X No

26. Placa of Death (Check only ona)

Hospital: 1 Inpatiant 2 ER/Outpatiant 3 DOA

Other: 4 X Nursing Homa 5 Rasidance 6 Other (Specify)

27. Manner of Death: 1 X Natural 2 Accidant 3 Suicide 4 Homicida 5 Panding investigation 6 Could not be datarmined

28a. Data of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 Yas 2 No

28d. Dascribe how injury occurred

28a. Place of Injury - At homa, farm, straat, factory, office building, atc. (Specify)

28f. Location (Street and Number or Rural Routa Number, City or Town, Stata)

29a. Certifier (Check only one): 1 X **Certifying Physician:** To tha best of my knowledga, daath occurred at tha tima, data and place, and dua to tha causa(s) and mannar as stated. 2 **Medical Examinar:** On tha basis of axamination and/or investigation, in my opinion, daath occurred at tha tima, data and place, and dua to tha csusa(s) and manner stated.

29b. Signature and title of certifier: MD

29c. Licanse number: D55027

29d. Date signed (Month, Day, Year): MARCH 16th, 2001

30. Name and addrass of person who completed ceusa of daath (Item 23a) (Type, Print): Manoj Panwala, M.D. 110 Hospital Road Suite #303 Prince Frederick, Maryland 20678

State Registrar

31. Deta filed (Month, Day, Year): MAR 19 2001

32. Registrar's Signatura: Geneva G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

1441 Graff St

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

ADMEND ITEM: #20B PER F.H. G794 4-21-01 WR

Certificate of Death

Reg. No. 2001 10047

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Bertha Louisa Miller

2. Date of Death Month Day Year: March 19, 2001

3. Time of Death: 6:00 AM

4a. Facility Name (If not institution, give street and number): Homestead Manor

4b. City, Town, or Location of Death: Denton

4c. County of Death: Caroline

Funeral Director

5. Social Security Number: 218-20-4717

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 85 Yrs.

If Under 1 Yaar: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Dey, Year): November 17, 1915

9. Birthplace (State or Foreign Country): Connecticut

Usual Residence of Decedent

10a. State: Maryland

10b. County: Caroline

10c. City, Town or Location: Denton

10d. Inside City Limits: 1☒ Yas 2☐ No

10e. Street and Number: 714 Market Street

10f. Zip Code: 21629

10g. Citizen of Whet Country?: United States

11. Marital Status: 1☐ Nevar Married 2☐ Married 3☐ Widowed 4☒ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yas 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: Caucasian

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondery (0-12): 11 HS Grad.

College (1-4or 5+): 1

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Financial Secretary

16b. Kind of Business/Industry: Board of Education

17. Father's Nama (First, Middla, Last): Charles Gustav Miller

18. Mother's Name (First, Middle, Maiden Sumema): Anna Marie Muller

19a. Informant's Name/Relationship (Type, Print): Kathleen Porter Personal Representative

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 14152 Cedar Lane, Greensboro, Maryland 21639

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from Stata 4☐ Donation 5☐ Other (Specify)

20b. Placa of Disposition (Name of cemetery, crematory or othar place): Capitol Crematory

Date: 3-24-01

20c. Location - City or Town, State: Dover, Delaware

21. Signature of Funeral Service Licensee: Randolph Moore

22. Nama and Address of Facility: Moore Funeral Home, P.A. 12 South Second Street, Denton, Maryland 21629

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

CARolin2

Physician /Medical Examiner

23a. Part1. Entar the disease, or complications that caused the daath. Do not enter tha mode of dying, such as cardiac or respiretory arrest, shock, or heart failure. List only ona cause on each lina.

Approximate Interval Between Onsat and Daath

Immediate Cause (Final diseese or condition resulting in death): a. Pancreatic Cancer — 1 month

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated avents resulting in death) Last

b. Due to (or as a consequenca of):

c. Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Ware autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case raferred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residenca 6☐ Other (Specify)

27. Manner of Death: 1☒ Naturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending invastigation 6☐ Could not be determined

28a. Dete of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Placa of Injury - At home, farm, street, factory, offica building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

29a. Certifier (Check only one): 1☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Karen Moffett

29c. License number: D51839

29d. Data signed (Month, Day, Year): 3-19-01

30. Neme and eddress of person who completed cause of death (Item 23a) (Type, Print): Karen Moffett, M.D., Daffin Lane, Denton, Maryland 21629

State Registrar

31. Date filed (Month, Dey, Year): MAR 2 1 2001

32. Registrar's Signature: D. Sparks

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 10048

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
JOSEPH ALBERT O'NEILL	March 6, 2001	5:30 AM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
806 The Terrace	Hagerstown	Washington

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
179-12-2316	1☒M 2☐F	79 Yrs.			Feb. 9, 1922	Pennsylvania

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Washington	Hagerstown	1☒Yes 2☐No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
806 The Terrace	21742	U.S.A.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐Never Married 2☐Married 3☒Widowed 4☐Divorced	1☒Yes 2☐No If Yes, Give Year or Dates: 1942 1945	1☐Yes 2☒No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
10	0	Owner/ Operator	Beverage Company

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Lawrence O'Neill	Elizabeth Donohue

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Jerry D. O'Neill / Son	20624 N.E. 34th Place Sammamish, Washington 98074

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	Rest Haven Cemetery	Mar. 10, 2001	Hagerstown, Maryland

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ Douglas A. Fiery	Douglas A. Fiery Funeral Home 1331 Eastern Blvd. N. Hagerstown, Maryland 21742

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. ALCOHOL ABUSE; CORONARY ARTERY DISEASE	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of):	
	c. Due to (or as a consequence of):	
	d. Due to (or as a consequence of):	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month Day Year
1☐Yes 2☐No 9☐Unknown	1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Hypertension; PROSTATE CANCER

23e. Did tobacco use contribute to the cause of death?	24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐Yes 2☒No 3☐Probably 4☐Unknown	1☐Yes 2☒No	1☐Yes 2☐No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐Yes 2☒No	Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA	Other: 4☐Nursing Home 5☒Residence 6☐Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined		M	1☐Yes 2☐No	
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification; To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one)
1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ Eli Roza	D0022313	3-14-01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Eli Roza MD 12931 Oak Hill Avenue Hagerstown, Md. 21742

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
MAR 14 2001	

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Vasuna

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 10049

Elizabeth Richards March 17, 2001 1:40p

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Elizabeth Ethel Richards
2. Date of Death: Month MARCH Day 17 Year 2001
3. Time of Death: 1:40p
4a. Facility Name (If not institution, give street end number): MANOKIN MANOR NURSING HOME
4b. City, Town, or Location of Death: Princess Anne
4c. County of Death: SOMERSET

Funeral Director

5. Social Security Number: 220-32-1271
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 100 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 03-11-1901
9. Birthplace (State or Foreign Country): MD

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: MD
10b. County: SOMERSET
10c. City, Town or Location: Princess Anne
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street end Number: 30566 South ST.
10f. Zip Code: 21853
10g. Citizen of What Country? U.S.A
11. Meritel Status: 1☐ Never Merried 2☐ Married 3☒ Widowed 4☐ Divorced
12. Wes Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yeer or Detes:
13. Wes Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Rece - American Indien, Bleck, White, etc. Specify: Black
15. Decedent's Education (Specify only highest grede completed): Elementary/Secondery (0-12): 12th | College (1-4or 5+):
18a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired): SELF-EMPLOYED
16b. Kind of Business/Industry: Beautician
17. Fether's Neme (First, Middle, Last): John Cottman
18. Mother's Neme (First, Middle, Maiden Surneme): BESSIE Nutter
19a. Informent's Neme/Relationship (Type, Print): Kevin Cottman - NEPHEW
19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code): 14385 Dogwood Dr. Eden, MD 21822
20a. Method of Disposition: 1☒ Burieł 2☐ Cremetion 3☐ Removel from State 4☐ Donetion 5☐ Other (Specify)
20b. Pleca of Disposition (Neme of cemetery, cremetory or other plece): John Wesley U.M.C Cemetery
Dete: 3-22-01
20c. Location - City or Town, Stete: Princess Anne, MD
21. Signature of Funeral Service Licensee: Anthony E. Ward
22. Neme and Address of Fecility: Anthony E. Waird Funeral Homo 30639 Hampden Ave Princess Anne, MD 21853

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Pert I. Enter the disease, or complications thet caused the death. Do not enter the mode of dying, such es cardiec or respiretory errest, shock, or heart failure. List only one ceuse on eech line.

Approximete Intervel Between Onset end Death

Immediete Ceuse (Finel diseese or condition resulting in deeth): e. ASCVD
Due to (or es e consequence of):
Sequentiellγ list conditions, if eny, leeding to immediete cause. Enter Underlying Ceuse (Diseese or Injury thet initieted events resulting in deeth) Last:
b. Dementia
Due to (or es e consequence of):
c.
Due to (or es e consequence of):
d.

Pert II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Pert I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Wes an eutopsy performed? 1☐ Yes 2☒ No
24b. Were eutopsy findings eveileble prior to completion of ceuse of deeth? 1☐ Yes 2☒ No

25. Wes case referred to medical examiner? 1☐ Yes 2☒ No
26. Plece of Deeth (Check only one): Hospitel: 1☐ Inpetient 2☐ ER/Outpetient 3☐ DOA | Other: 4☒ Nursing Home 5☐ Residenca 6☐ Other (Specify)
27. Menner of Deeth: 1☒ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Dete of Injury (Month, Dey Yeer)
28b. Time of Injury M
28c. Injury et Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Plece of Injury - At home, ferm, street, fectory, offica building, etc. (Specify)
28f. Location (Street and Number or Rurel Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, dete end pleca, end due to the ceuse(s) end menner es steted. 2☐ **Medicel Examiner:** On the basis of examinetion end/or investigetion, in my opinion, death occurred et the time, dete end placa, and due to the ceuse(s) end menner steted.

29b. Signeture end title of certifier: Natesan
29c. License number: 047094
29d. Dete signed (Month, Dey, Yeer): 3/17/01

30. Neme and eddress of person who completed cause of deeth (Item 23a) (Type, Print): NATESAN 106 PINE BLUFF ROAD SALISBURY MD 21801

State Registrar

31. Dete filed (Month, Day, Year): MAR 19 2001
32. Registrar's Signeture: Jennie G. Sparks

DHMH 16 Rev 6/95

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 10050

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: ELEANOR M. STERLING
2. Date of Death Month Day Year: March 12, 2001
3. Time of Death: 9:00 AM
4a. Facility Name *(If not institution, give street and number)*: E. W. McCready Memorial Hospital
4b. City, Town, or Location of Death: Crisfield
4c. County of Death: Somerset

Funeral Director

5. Social Security Number: 217-12-4293
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 78 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: Oct. 13, 1922
9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Somerset
10c. City, Town or Location: Crisfield
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 206 N. Somerset Ave.
10f. Zip Code: 21817
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No — If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 — College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Saleslady
16b. Kind of Business/Industry: Department Store

17. Father's Name *(First, Middle, Last)*: Waters Tull
18. Mother's Name *(First, Middle, Maiden Surname)*: Elsie Marie Tull

19a. Informant's Name/Relationship *(Type, Print)*: William R. Sterling (husband)
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 206 N. Somerset Ave. - Crisfield, MD 21817

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetary, crematory or other place)*: Sunnyridge Memorial Park
Date: 3/15/01
20c. Location - City or Town, State: Crisfield, MD

21. Signature of Funeral Service Licensee: Robert H. Bradshaw
22. Name and Address of Facility: Bradshaw & Sons Funeral Home, 306 W. Main St. - Crisfield, MD 21817

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. CONGESTIVE HEART FAILURE

Due to (or as a consequence of):
b. CORONARY ARTERY DISEASE

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death *(Check only one)*: Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 8☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier
29c. License number: D 48098
29d. Date signed *(Month, Day, Year)*: MARCH 12, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Vijay Karumbunathan, M.D. - 201 Hall Highway - Crisfield, MD 21817

State Registrar

31. Date filed *(Month, Day, Year)*: MAR 14 2001
32. Registrar's Signature: Geneva G. Sparks

DHMH 16 Rev 6/95

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 10051

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Norma Shores
2. Date of Death: Month March Day 16 Year 2001
3. Time of Death: 2:45pm
4a. Facility Name (If not institution, give street and number): Manokin Manor
4b. City, Town, or Location of Death: Princess Anne
4c. County of Death: Somerset

Funeral Director

5. Social Security Number: 217-36-2000
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 80 Yrs. — If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 08/28/1920
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: MD
10b. County: Somerset
10c. City, Town or Location: Princess Anne
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 11974 Edgehill Terrace
10f. Zip Code: 21853
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No — If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementery/Secondery (0-12): 12; College (1-4or 5+): 4
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Social Worker
16b. Kind of Business/Industry: Social Services

17. Father's Name (First, Middle, Last): William O. Murray
18. Mother's Name (First, Middle, Maiden Surname): Mamie Hopkins

19a. Informant's Name/Relationship (Type, Print): Charlotte Shores Benton/Daughter
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 23659 Tom Price Road, Chance, MD 21816

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Asbury U.M. Cemetery
Date: 3/18/01
20c. Location - City or Town, State: Mt. Vernon, Maryland

21. Signature of Funeral Service Licensee: James L Hinman M00295
22. Name and Address of Facility: Hinman Funeral Home, 11673 Somerset Ave., Princess Anne, MD 21853

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one ceuse on eech line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. End Stage Senile Dementia	5 yrs
	Due to (or as a consequence of):	
Sequentially list conditions, if any, leeding to Immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in death) Last	b.	
	Due to (or as a consequence of):	
	c.	
	Due to (or as a consequence of):	
	d.	

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Pneumonia. Chronic Obstructive Pulmonary Disease. Anemia. Failure to Thrive. Old CVA

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Daeth: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined
28a. Dete of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Piece of Injury - At home, tarm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and piece, end due to the ceuse(s) and manner as stated. 2☐ Medical Examiner: On tha basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: Gregorio M. Belloso MD
29c. License number: D 29505
29d. Date signed (Month, Day, Year): 3-19-2001
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): GREGORIO M. BELLOSO, M.D. 5302 CHINABERRY DR., SALISBURY, MD 21801

State Registrar

31. Date filed (Month, Day, Year): MAR 20 2001
32. Registrar's Signature: Geneva G. Sparks

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Norma Shores
Baltimore, Maryland 21215-0020

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 10052

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): David L. Shawkey, Sr.
2. Date of Death: Month 3 Day 25 Year 01
3. Time of Death: 1130 A M
4a. Facility Name (If not institution, give street and number): Saint Joseph Hospital
4b. City, Town, or Location of Death: Towson
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 214-46-0288
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 53 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): May 6, 1947
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Harford
10c. City, Town or Location: Jarrettsville
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 4162 Madonna Road
10f. Zip Code: 21084
10g. Citizen of What Country? U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12):
College (1-4or 5+): 1 yr.
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
16b. Kind of Business/Industry

17. Father's Name (First, Middle, Last): Herman Shawkey
18. Mother's Name (First, Middle, Maiden Surname): Sylvia E. Farley

19a. Informant's Name/Relationship (Type, Print): Lynda Shawkey, wife
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21084: 4162 Madonna Road, Jarrettsville, Maryland

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Glen Haven Memorial Park
Date: March 29, 2001
20c. Location - City or Town, State: Glen Burnie, Maryland

21. Signature of Funeral Service Licensee: Brenda S. Wells
22. Name and Address of Facility: Evans Funeral Chapel 3 Newport Dr. Forest Hill, Md 21050

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. metastatic lung Carcinoma — 1 month
Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d.

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1 [ ] Yes 2 [X] No 9 [ ] Unknown
23c. If yes, outcome of pregnancy: 1 [ ] Live birth 2 [ ] Fetal death 3 [ ] Ectopic pregnancy 4 [ ] Pregnant at time of death 5 [ ] Other (specify) 9 [ ] Unknown
23d. Date of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [X] Probably 4 [ ] Unknown
24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [ ] No
28. Place of Death (Check only one)
Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA
Other: 4 [ ] Nursing Home 5 [ ] Residence 8 [ ] Other (Specify)

27. Manner of Death: 1 [ ] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification; To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: John C Downs MD
29c. License number: D33624
29d. Date signed (Month, Day, Year): 3/26/01
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): John C Downs 7505 Osler Drive, Suite 302 Towson MD 21204 MARYland Oncology P.A.

State Registrar

31. Date filed (Month, Day, Year): MAR 28 2001
32. Registrar's Signature: Donna B Sparks

To be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

#3

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 10053

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
ROSS LORRAINE SCHULZ	MARCH 26, 2001	11:39 A M.

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
103 HOLY CROSS ROAD	STREET	HARFORD

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
217-14-0710	1 ☐ M 2 ☒ F	79 Yrs.			MARCH 31, 1922	MARYLAND

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MARYLAND	HARFORD	STREET	1 ☐ Yes 2 ☒ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
103 HOLY CROSS ROAD	21154	U.S.A.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.)	14. Race - American Indien, Black, White, etc.
1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:	1 ☐ Yes 2 ☒ No Specify:	Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
11 YRS.		OFFICE CLERK	RETAIL

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
WILLARD E. FALES	PEARL E. MASON

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) 21154
KENNETH E. SCHULZ	103 HOLY CROSS ROAD STREET, MARYLAND

20a. Method of Disposition	20b. Piece of Disposition (Name of cemetery, crematory or other piece)	Date	20c. Location - City or Town, State
1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from Stete 4 ☐ Donation 5 ☐ Other (Specify)	MARYLAND MEMORIAL PARK	MARCH 29, 2001	PARKVILLE MARYLAND

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶	EVANS FUNERAL CHAPEL—BLAIR, P.A. 3 NEWPORT DRIVE FOREST HILL MARYLAND

Physician /Medical Examiner

Medical Certification; To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset end Death

Immediate Cause (Final disease or condition resulting in death)
- a. chronic renal failure.

Due to (or as e consequence of):
- b. A.S.C.V.D.

Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as e consequence of):
- c.

Due to (or as e consequence of):
- d.

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnency	23d. Date of delivery Month Day Year
1 ☐ Yes 2 ☒ No 9 ☐ Unknown	1 ☐ Live birth 2 ☐ Fetel deeth 3 ☐ Ectopic pregnency 4 ☐ Pregnent et time of deeth 5 ☐ Other (specify) 9 ☐ Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobecco use contribute to the cause of death? 1 ☐ Yes 2 ☒ No 3 ☐ Probebly 4 ☐ Unknown

24a. Was en autopsy performed?	24b. Were autopsy findings evaileble prior to completion of cause of deeth?
1 ☐ Yes 2 ☒ No	1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)
1 ☐ Yes 2 ☒ No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined		M	1 ☐ Yes 2 ☐ No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street end Number or Rurel Route Number, City or Town, State)

29a. Certifier (Check only one)
- 1 ☒ **Certifying Physician:** To the best of my knowledge, death occurred et the time, date and place, end due to the cause(s) end menner es stated.
- 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date end place, end due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Dete signed (Month, Day, Yeer)
▶ David S. Dunn	032297	March 28, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
DR. DAVID S. DUNN, M.D. 615 WEST MacPHAIL ROAD BEL AIR, MARYLAND

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
MAR 28 2001	▶ Jeanne B Sparks

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23e or 28e-f show any injury or other treumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 10054

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Virginia Waters

2. Date of Death Month Day Year: MARCH 17, 2001

3. Time of Death: 4:25pm

4a. Facility Name (If not institution, give street and number): MANOKIN MANOR NURSING HOME

4b. City, Town, or Location of Death: Princess Anne

4c. County of Death: Somerset

Funeral Director

5. Social Security Number: 219-22-4018

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 75 Yrs. | If Under 1 Yaar: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): 07/24/1925

9. Birthplace (State or Foreign Country): Virginia

Usual Residence of Decedent

10a. State: MD

10b. County: Somerset

10c. City, Town or Location: Princess Anne

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 11974 Edgehill Terrace

10f. Zip Code: 21853

10g. Citizen of Whet Country?: USA

11. Maritai Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedant Ever in U,S. Armed Forces? 1☐ Yas 2☒ No If Yes, Give Year or Dates:

13. Was Dacedant of Hispanic Origin? (Specify Yes or No- If Yas, specify Cuban, Mexicen, Puarto Rican, atc.) 1☐ Yes 2☒ No Specify:

14. Race - Americen Indian, Black, Whita, atc. Specify: White

15. Decedent's Educetion (Specify only highast grada complated): Elementary/Secondery (0-12): 11 | College (1-4or 5+): none

16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired): Housewife

16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): William Thomas Pruitt

18. Mother's Name (First, Middle, Maiden Surname): Nettie Lee Crockett

19a. Informant's Name/Relationship (Type, Print): Gloria Waters Horner/Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 9367 Deal Island Road, Deal Island, MD 21821

20a. Mathod of Disposition: 1☐ Buriai 2☒ Cremation 3☐ Ramoval from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cematery, crematory or other place): Salisbury Crematory

Date: 3/19/01

20c. Location - City or Town, Stata: Salisbury, MD

21. Signature of Funeral Service Licensae: James L. Hinman M00295

22. Name and Address of Facility: Hinman Funeral Home 11673 Somerset Ave., Princess Anne, Md. 21853

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiretory errest, shock, or heart failure. List only one cause on each line.

Approximete Intervel Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Foot gangrene

Due to (or as a consequence of): b. COPD

Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of): c. PVD

Due to (or as a consequence of): d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☒ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medicel examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpetient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Deeth: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, straet, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, Stata)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at tha time, date and place, and due to the ceuse(s) and manner es steted. 2☐ **Medical Examiner:** On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: NATSAN

29c. Licansa number: D47094

29d. Date signed (Month, Day, Year): 3/17/01

30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print): NATESAN 106 PINE BLAFF ROAD SALISBURY MD 21801

State Registrar

31. Date filed (Month, Day, Year): MAR 20 2001

32. Registrar's Signature: Geneva G. Sparks

To be Completed by Funeral Director

permit. Pagas 1 and 2 should be filed within 72 hours aftar death with tha Meryland Department of Health and Mental Hygiana. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Virginia P. Waters March 17, 2001 at 4:35p.m. Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: Tha law requires that tha death certificate be executed within 24 hours aftar death.

To the Funeral Director: After this certificate has been signed by the attending physician and completaly filled in by the funeral director, page 2 should be datached tor usa as tha burial-transit

Division of Vital Records, P.O. Box 68760,

RB

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 10055

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): JAMES WALL
2. Date of Death (Month, Day, Year): MARCH 18, 2001
3. Time of Death: 14:19
4a. Facility Name (If not institution, give street and number): Calvert Memorial Hospital
4b. City, Town, or Location of Death: Prince Frederick
4c. County of Death: Calvert

Funeral Director

5. Social Security Number: 219-12-3340
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 78 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Aug. 26, 1922
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Calvert
10c. City, Town or Location: Prince Frederick
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 214 Hallowing Point Road
10f. Zip Code: 20678
10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: 1945-1946
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 7 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Heavy Equipment Operator
16b. Kind of Business/Industry: Construction

17. Father's Name (First, Middle, Last): Cephas Wall
18. Mother's Name (First, Middle, Maiden Surname): Jennie V. Brooks

19a. Informant's Name/Relationship (Type, Print): Alberta Wall/Daughter
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): P.O. Box 1961 Prince Frederick, MD 20678

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Browns Church Cemetery
Date: 3/22/01
20c. Location - City or Town, State: Port Republic, MD

21. Signature of Funeral Service Licensee: ▶ Gladys G. Sewell
22. Name and Address of Facility: Sewell Funeral Home 1451 Dares Beach Rd. Prince Frederick, MD 20678

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Massive myocardial Infarction
Due to (or as a consequence of):
b. Coronary Artery Disease
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [X] Yes 2 [ ] No
26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [X] DOA | Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)
27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Raymon Noble MD
29c. License number: D 17324
29d. Date signed (Month, Day, Year): 3/19/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Dr. Raymon Noble, MD, Huntingtown, Maryland 20639

State Registrar

31. Date filed (Month, Day, Year): MAR 2 1 2001
32. Registrar's Signature: ▶ Geneva G Sparks

2+1

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 10056

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): GEORGIA WILLETT
2. Date of Death (Month, Day, Year): MARCH 20, 2001
3. Time of Death: 03:05am
4a. Facility Name (If not institution, give street and number): Calvert Memorial Hospital
4b. City, Town, or Location of Death: Prince Frederick
4c. County of Death: Calvert

Funeral Director

5. Social Security Number: 213-38-1349
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 80 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Dec. 25, 1920
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Calvert
10c. City, Town or Location: Prince Frederick
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 5125 Macs Hollow Road
10f. Zip Code: 20678
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 11 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Housekeeper
16b. Kind of Business/Industry: Hospital

17. Father's Name (First, Middle, Last): Elijah Greene
18. Mother's Name (First, Middle, Maiden Surname): Mattie Holland

19a. Informant's Name/Relationship (Type, Print): Betty L. Jacks/Daughter
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 5305 Macs Hollow Road Prince Frederick, MD 20678

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Carroll Western Cemetery
Date: 3/24/01
20c. Location - City or Town, State: Prince Frederick, MD

21. Signature of Funeral Service Licensee: ▶ Gladys G. Sewell
22. Name and Address of Facility: Sewell Funeral Home 1451 Dares Beach Rd. Prince Frederick, MD 20678

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death):
a. CONGESTIVE HEART FAILURE — several years

Due to (or as a consequence of):
b. CORONARY ARTERY DISEASE

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
(1) Chronic Obstructive Pulmonary Disease
(2) Diabetes Mellitus

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)
27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: ▶ A T Munshi, M.D. Attending Physician
29c. License number: D19427
29d. Date signed (Month, Day, Year): 3/20/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): ANWAR T. MUNSHI, M. D., PRINCE FREDERICK, MD 20678

State Registrar

31. Date filed (Month, Day, Year): MAR 21 2001
32. Registrar's Signature: ▶ Geneva G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 10057

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Raymond Edward Avis

2. Date of Death: Month: April Day: 1 Year: 2001

3. Time of Death: 4:49AM

4a. Facility Name (If not institution, give street and number): Sinai Hospital of Baltimore

4b. City, Town, or Location of Death: Baltimore

4c. County of Death:

Funeral Director

5. Social Security Number: 216-12-2552

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 82 Yrs.

If Under 1 Year: Months: Days: If Under 24 Hrs.: Hours: Min.:

8. Date of Birth (Month, Day, Year): Oct. 2, 1918

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: MD

10b. County: Baltimore

10c. City, Town or Location: Lochearn

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 6629 Brighton Avenue

10f. Zip Code: 21215

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: WWII

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementery/Secondery (0-12): 10 College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Foreman

16b. Kind of Business/Industry: University of Maryland

17. Father's Name (First, Middle, Last): George B. Avis

18. Mother's Name (First, Middle, Maiden Surname): Emily (unk)

19a. Informant's Name/Relationship (Type, Print): Timothy R. Avis (Son)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 6629 Brighton Avenue; Baltimore, Maryland 21215

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, cremetory or other place): Lorraine Park Cemetery

Date: 4/4/01

20c. Location - City or Town, State: Woodlawn, Maryland

21. Signature of Funeral Service Licensee: ▶ [signature] M00869

22. Name and Address of Facility: Loring Byers Funeral Directors, Inc. 8728 Liberty Road; Randallstown, Maryland 21133

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Respiratory Acidosis

Due to (or as a consequence of): b. Pleural Effusion

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of): c.

Due to (or as a consequence of): d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I: Cirrhosis, Coronary Artery Disease

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of ceuse of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Netural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Panding investigetion 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Piece of Injury - At home, ferm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] Certifying Phyaician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and mannar as stated. 2 [ ] Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Shakil Khan M.D.

29c. License number: P-13206

29d. Date signed (Month, Dey, Year): April 1, 2001

30. Name and address of parson who completed ceuse of death (Item 23a) (Type, Print): Shakil Khan Sinai Hospital 2401 West Belvedere Ave Baltimore, MD 21215

State Registrar

31. Dete filed (Month, Dey, Year): APR 03 2001

32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

Raymond E. Avis

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 10058

Physician /Medical Examiner

1. Decedent's Neme (First, Middle, Last): ASLEAN ATIGNS
2. Date of Deeth (Month, Dey, Yeer): 3 - 25 2001
3. Time of Death: 9.55 aM
4e. Facility Name (If not institution, give street end number): GENESIS ELDER CARE
4b. City, Town, or Location of Deeth: RANDALLSTOWN
4c. County of Deeth: BALTIMORE

Funeral Director

5. Social Security Number: 212-52-2526
6. Sex: 1☐ M 2☑ F
7. Age (In yrs. last birthdey): 54 Yrs. | If Under 1 Year: Months / Deys | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 11-03-1946
9. Birthplace (State or Foreign Country): MD

Usuel Residence of Decedent

10a. Stete: MD
10b. County: N/A
10c. City, Town or Location: BALTIMORE
10d. Inside City Limits: 1☑ Yes 2☐ No
10e. Street and Number: 833 SEAGUL AVENUE
10f. Zip Code: 21206
10g. Citizen of What Country: USA

11. Merital Stetus: 1☐ Never Married 2☐ Married 3☑ Widowed 4☐ Divorced
12. Wes Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☑ No If Yes, Give Yeer or Dates:
13. Wes Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specity Cuben, Mexicen, Puerto Rican, etc.) 1☐ Yes 2☑ No Specify:
14. Race - American Indian, Black, White, etc. Specify: BLACK

15. Decedent's Educetion (Specify only highest grede completed): Elementary/Secondary (0-12): 12TH GRADE | College (1-4or 5+): N/A
16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired): HOME MAKER
16b. Kind of Business/Industry: DOMESTIC

17. Father's Neme (First, Middle, Last): LEROY COLE, SR
18. Mother's Neme (First, Middle, Maiden Surname): MARY HOWARD

19e. Informent's Neme/Reletionship (Type, Print): ASLEAN MURRAY | AUNT
19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code): 10 DRAWBRIDGE CT., CATONSVILLE, MD. 21228

20a. Method of Disposition: 1☑ Burial 2☐ Cremetion 3☐ Removel from Stete 4☐ Donetion 5☐ Other (Specify)
20b. Plece of Disposition (Neme of cemetery, cremetory or other plece): WEST LIBERTY UM CEMETERY
Date: 03.31.01
20c. Location - City or Town, Stete: MARRIOTTSVILLE, MD

21. Signeture of Funerel Service Licensee: ▶ Vaughn C
22. Neme end Address of Feciility: VAUGHN C. GREENE FUNERAL SERVICE 5151 BALTO. NATL' PIKE, BALTO. MD 21229

Physician /Medical Examiner

23a. Pert1. Enter the diseese, or complicetions thet caused the deeth. Do not enter the mode of dying, such es cerdiec or respiretory arrest, shock, or heert feilure. List only one ceuse on eech line. (Approximate Intervel Between Onset and Deeth)

Immediete Ceuse (Finel disease or condition resulting in death): e. PERSISTENT VEGETATIVE STATE

Due to (or es e consequence of): STROKE

Sequentially list conditions, if any, leading to immediete cause. Enter Underlying Cause (Diseese or Injury thet initieted events resulting in death) Last:
b.
Due to (or es e consequence of):
c.
Due to (or es e consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Part I.: HYPERTENSION ; PEG TUBE

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

24a. Wes an autopsy performed? 1☐ Yes 2☑ No
24b. Were autopsy findings eveilable prior to completion of cause of death? 1☐ Yes 2☐ No

25. Wes case referred to medical exeminer? 1☐ Yes 2☑ No
26. Place of Death (Check only one): Hospital: 1☐ Inpetient 2☐ ER/Outpetient 3☐ DOA | Other: 4☑ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Menner of Death: 1☑ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28e. Dete of Injury (Month, Dey Yeer)
28b. Time of Injury
28c. Injury et Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street end Number or Rurel Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☑ **Certifying Physician**: To the best of my knowledge, deeth occurred et the time, date end plece, end due to the cause(s) and menner as stated. 2☐ **Medical Examiner:** On the basis of exemination end/or investigation, in my opinion, deeth occurred et the time, date and place, and due to the ceuse(s) and menner steted.

29b. Signeture and title of certifier: ▶ [signature]
29c. License number: D52360
29d. Date signed (Month, Dey, Yeer): 3/26/01

30. Neme and eddress of person who completed cause of death (Item 23a) (Type, Print): CULBIR GANDHI 1838 GREENE TREE RD. SUITE 300 PIKESVILLE MD 21208

State Registrar

31. Date filed (Month, Dey, Yeer): APR 0 3 2001
32. Registrer's Signeture: ▶ [signature] G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the funeral director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

RJD
LINDA BARFIELD
01-1752-510

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar UNPENDED 011402: ITEMS #23a, 27, 28a-f per ME G303 ss

Certificate of Death

Reg. No. 2001 10059

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
LINDA J. JACKSON BARFIELD	MARCH 30, 2001	0040A. M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
JOHNS HOPKINS HOSPITAL	BALTIMORE	N/A

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
214-68-4181	1☐M 2☑F	45 Yrs.			01-26-1956	MD

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	BALTIMORE	GLEN BURNIE	1☐Yes 2☑No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
6458 HARRISON SQUARE	21061	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Rece - American Indian, Black, White, etc.
1☐Never Married 2☑Married 3☐Widowed 4☐Divorced	1☐Yes 2☑No If Yes, Give Year or Dates:	1☐Yes 2☑No Specify:	Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
9TH GRADE	N/A	PATIENT CARE	ASSISTED LIVING

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Meiden Sumame)
CHARLES JACKSON	MABEL FLEMMING

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
TANYA BRADSHAW / DAUGHTER	6458 HARRISON SQ., GLEN BURNIE, MD 21061

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☑Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	ARBUTUS CEMETERY	04.03.01	BALTO. MD

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ Vaughn C [illegible]	VAUGHN C. GREENE FUNERAL SERVICE 5151 BALTO. NAT'L PIKE, BALTO. MD. 21229

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

Medical Certification; To Be Completed by Physician/Medical Examiner

23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such es cardiec or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. PANCREATITIS WITH COMPLICATIONS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

IF FEMALE: 23b. Wes decedent pregnant in the past 12 months? 1☐Yes 2☐No 9☐Unknown	23c. If yes, outcome of pregnency 1☐Live birth 2☐Fetel death 3☐Ectopic pregnancy 4☐Pregnent at time of deeth 5☐Other (specify) 9☐Unknown	23d. Date of delivery Month Day Year

Part ii. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobecco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☒Unknown

24a. Was an autopsy performed? 1☒Yes 2☐No	24b. Were autopsy findings available prior to completion of cause of death? 1☒Yes 2☐No

25. Was case referred to medical examiner? 1☒Yes 2☐No

28. Place of Death (Check only one)
Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA
Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Deeth: 1☐Naturat 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☒Could not be determined

28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work? 1☐Yes 2☒No	28d. Describe how injury occurred
Unknown	Unknown M		Unknown

28e. Place of tnjury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street end Number or Rurel Route Number, City or Town, State)
Unknown	Unknown

29a. Certifier (Check only one)
1☐ **Certifying Physician:** To the best of my knowledge, death occurred et the time, date and place, end due to the cause(s) end manner as stated.
2☒ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date end piece, and due to the ceuse(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ Theodore M. King MD	O.C.M.E.	MARCH 30, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
THEODORE M. KING 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
APR 03 2001	[signature]

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

AMEND ITEM 23a, ptII per phys G794 040301 SS
AMEND ITEM 19a per fh G794 040301 SS

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 10060

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): DYLAN BERRY
2. Date of Death: Month March, Day 9, Year 2001
3. Time of Death: 1926
4a. Facility Name (If not institution, give street and number): The Johns Hopkins Hospital
4b. City, Town, or Location of Death: Baltimore
4c. County of Death:

Funeral Director

5. Social Security Number: 217-59-6647
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday) Yrs.: If Under 1 Year: Months 02, Days 08; If Under 24 Hrs.: Hours, Min.
8. Date of Birth (Month, Day, Year): 12 29 00
9. Birthplace (State or Foreign Country): M.D.

Usual Residence of Decedent

10a. State: MD
10b. County: Baltimore
10c. City, Town or Location: Woodlawn
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 6828 Townbrook Drive Apt c
10f. Zip Code: 21207
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): N/A; College (1-4or 5+): N/A
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): N/A
16b. Kind of Business/Industry: N/A

17. Father's Name (First, Middle, Last): Darin Berry
18. Mother's Name (First, Middle, Maiden Surname): Nicole Vann

19a. Informant's Name/Relationship (Type, Print): Nicole Berr-Mother
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21207: 6828 Townbrook Drive Apt c, Woodlawn, Md

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): King Memorial Park
Date: 3/15/01
20c. Location - City or Town, State: Randallstown, Md

21. Signature of Funeral Service Licensee: Larry A Shivers
22. Name and Address of Facility: March F/H West, 4300 Wabash Ave, Baltimore Md 21215

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. ~~Aspiration~~ GASTROESOPHAGEAL REFLUX PRODUCING ASPIRATION — 35 min

Due to (or as a consequence of):
b. ~~Complete heart block s/p pacemaker~~ PREMATURITY — Lifetime

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):
c. ~~Gastroesophageal Reflux~~ — Lifetime

Due to (or as a consequence of):
d. ~~s/p pulmonary Embolus~~ — 1 week

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
CHRONIC EMBOLUS 1 WEEK PRIOR TO DEATH
~~Chronic lung disease due to prematurity~~
CONGENITAL COMPLETE A-V BLOCK W/ VVI PACEMAKER

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

28. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: R RINGEL, MD
29c. License number: D0025806
29d. Date signed (Month, Day, Year): 3/9/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): RICHARD E. RINGEL, MD Johns Hopkins Hospital 600 N. Wolfe Street

State Registrar

31. Date filed (Month, Day, Year): APR 0 3 2001
32. Registrar's Signature: Geneva G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

SS

2

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 10061

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)			2. Date of Death Month	Day	Year	3. Time of Death
Mary L. Brown			3	29	2001	4:10 a. M
4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death			
Gardenview N/H	Baltimore		N/A			

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months	Days	If Under 24 Hrs.: Hours	Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
212-34-3320	1☐M 2☒F	85 Yrs.					1-22-1916	Md

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Md	N/A	Baltimore	1☒Yes 2☐No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
1820 Harlem Avenue	21217	U S A

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐Never Married 2☐Married 3☒Widowed 4☐Divorced	1☐Yes 2☒No If Yes, Give Year or Dates:	1☐Yes 2☒No Specify:	Specify: Black

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12th grade	N/A		

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Thomas Dent	Mary Moore Rush

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Matthew Brown, Jr - Son	1820 Harlem Avenue Baltimore, Md 21217

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	Baltimore Cemetery	4-3-2001	Baltimore, Md

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ Elmore A. Thompson	March F/H West 4300 Wabash Avenue Baltimore, Md 21215

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Arteriosclerotic Cardiovascular disease

Due to (or as a consequence of):

b. Hypertensive Cardiovascular disease

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c. Multiple decubitus ulcers

Due to (or as a consequence of):

d. Pneumonia

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month Day Year
1☐Yes 2☐No 9☐Unknown	1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

End Stage Renal Failure

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐Yes 2☒No	1☐Yes 2☐No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐Yes 2☒No	Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA	Other: 4☒Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined		M	1☐Yes 2☐No	

26e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification; To Be Completed by Physician/Medical Examiner

29e. Certifier (Check only one)

1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ [signature] M.D	D39127	4/3/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DR. A-AHMED 821 N. Eutaw Street Baltimore MD 21201

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
APR 03 2001	▶ Geneva G Sparks

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

5)

3

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 10062

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Johnnie R. Biddle

2. Date of Death: Month 03 Day 31 Year 2001

3. Time of Death: 7:20 PM

4a. Facility Name (If not institution, give street and number): Mercy medical Center

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: N/A

Funeral Director

5. Social Security Number: 231-34-0583

6. Sex: 1☐ M 2☑ F

7. Age (In yrs. last birthday): 82 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): 02 26 1918

9. Birthplace (State or Foreign Country): NORTH CAROLINA

Usual Residence of Decedent

10a. State: MARYLAND

10b. County: N/A

10c. City, Town or Location: BALTIMORE CITY

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 2527 PENNSYLVANIA AVENUE

10f. Zip Code: 21217

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 8th grade

College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): SERVICE DEPT SALE REP

16b. Kind of Business/Industry: SEARS

17. Father's Name (First, Middle, Last): JOHN

18. Mother's Name (First, Middle, Maiden Surname): MARY E DOCKINS

19a. Informant's Name/Relationship (Type, Print): Stephen E. Biddle Jr/Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 759 McKewin Avenue, Baltimore, Maryland 21218

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Cedar Hill Cemetery

Date: 04-06-01

20c. Location - City or Town, State: GLEN BURNIE, MARYLAND

21. Signature of Funeral Service Licensee:

22. Name and Address of Facility: WILLIAM C BROWN COMMUNITY FUNERAL HOME PA 1206 W NORTH AVENUE

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Bladder Carcinoma — Approximate Interval: months

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1☐ Yes 2☑ No 9☐ Unknown

23c. If yes, outcome of pregnancy: 1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnent at time of death 5☐ Other (specify) 9☐ Unknown

23d. Date of delivery: Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Respiratory failure

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death (Check only one): Hospital: 1☑ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier:

29c. License number:

29d. Date signed (Month, Day, Year): 03-31-01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): John F. Caccamese Jr, DMD, MD 301 St. Paul Place Baltimore, MD 21202

State Registrar

31. Date filed (Month, Day, Year): APR 03 2001

32. Registrar's Signature:

DHMH 17 Rev 1/2001

ORIGINAL

Medical Certification; To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 10063

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): John Boteler
2. Date of Death: Month 03 Day 29 Year 01
3. Time of Death: 9 44 AM
4a. Facility Name (If not institution, give street and number): Bon Secours Hospital
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: n/a

Funeral Director

5. Social Security Number: 219-16-6333
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 76 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Sept. 30, 1924
9. Birthplace (State or Foreign Country): Maryland

Usual Residance of Decedent

10a. State: Maryland
10b. County: n/a
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 1908 West Lombard Street
10f. Zip Code: 21223
10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 8 | College (1-4or 5+): 0
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Master Plumber
16b. Kind of Business/Industry: Plumbing Co.
17. Father's Name (First, Middle, Last): Gilbert Howard Boteler
18. Mother's Name (First, Middle, Maiden Surname): Barbara Margaret Luscorn
19a. Informant's Name/Relationship (Type, Print): Dorothy Boteler / Wife
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1908 West Lombard Street, Baltimore, Maryland 21223
20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetary, crematory or other place): Maryland Veterans Cemetery | Date: 4/3/01
20c. Location - City or Town, State: Owings Mills, Md.
21. Signature of Funeral Service Licensee: R. A. [illegible]
22. Name and Address of Facility: Hubbard Funeral Home, Inc. 4107 Wilkens Avenue, Baltimore, Maryland 21229

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) a.	Myocardial Infarction	1 day
Due to (or as a consequence of): b.	Congestive Heart Failure	1 YR
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last: Due to (or as a consequence of): c.	Pneumonia	1 WK
Due to (or as a consequence of): d.	Multiple Strokes	2 YRS

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 8 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature] M.D.
29c. License number: D0022632
29d. Data signed (Month, Day, Year): 03 · 30 · 01

30. Name and address of person who completed cause of death (item 23a) (Type, Print): Laurence Sapio, M.D. 2000 W. Baltimore Street Balt., MD 21223

State Registrar

31. Data filed (Month, Day, Year): APR 0 3 2001
32. Registrar's Signature: Geneva G Sparks

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 10064

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Myrtle Magdelene Becker
2. Date of Death (Month, Day, Year): March 31, 2001
3. Time of Death: 1:30 A.M.
4a. Facility Name (If not institution, give street and number): St. Joseph Medical Center
4b. City, Town, or Location of Death: Towson
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 215-28-8679
8. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 88 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): July 23, 1912
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Baltimore
10c. City, Town or Location: Lutherville
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 237 Meadowvale Road
10f. Zip Code: 21093
10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 9; College (1-4or 5+): -0-
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Library Clerk
16b. Kind of Business/Industry: Baltimore City Gov't.

17. Father's Name (First, Middle, Last): August Snyder
18. Mother's Name (First, Middle, Maiden Surname): Lisette Schwartz

19a. Informant's Name/Relationship (Type, Print): Louise D. Long (daughter)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 237 Meadowvale Road, Lutjerville, Maryland 21093

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, cremetory or other place): Woodlawn Cemetery
Date: April 4, 2001
20c. Location - City or Town, State: Woodlawn, Maryland

21. Signature of Funeral Service Licensee: Brian T.
22. Name and Address of Facility: Chisholm Funeral Services of Dualney Valley, P.A. 200 E. Padonia Road, Timonium, Maryland 21093

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. SEPSIS — 24 HOUR

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: HYPERTENSION

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☒ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ NRosenblum
29c. License number: D 23319
29d. Date signed (Month, Day, Year): APRIL 2 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): NATHAN ROSENBLUM 7600 OSLER DRIVE TOWSON, MD 21204

State Registrar

31. Date filed (Month, Day, Year): APR 0 3 2001
32. Registrar's Signature: ▶ Jeanne G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

ADH
DIANE BAYLUS
01-1761-013

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM 23a,ptII,27,28 per ME 041101 SS

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar AMND ITM#10E PER F.H. G794 4-3-2001JB

Certificate of Death

Reg. No. 2001 10065

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)			2. Date of Death Month	Day	Year	3. Time of Death
DIANE	RUTH	BAYLUS	MARCH	30,	2001	1850 P M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
88 WEST MAIN STREET #B-2	WESTMINSTER	CARROLL

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months	Days	If Under 24 Hrs.: Hours	Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
217-58-8915	1☐M 2☒F	34 Yrs.					APR.6,1966	MD

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	CARROLL	WESTMINSTER	☒1 Yes 2☐No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
88 ~~WEST~~ ~~EAST~~ MAIN STREET #B-2	21157	U.S.A.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
☒1 Never Married 2☐ Married 3☐ Widowed 4☐ Divorced	1☐Yes ☒2 No If Yes, Give Year or Dates:	1☐ Yes ☒2 No Specify:	Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
2		OPTICIAN	OPTOMETRY

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
ALVIN BAYLUS	MARIE SURASKY

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
MARIE SURASKY / MOTHER	6211 SAREVA DRIVE - BALTIMORE, MD 21209

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
☒1 Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)	BALTIMORE HEBREW CEM.	4/1/01	REISTERSTOWN, MD

21. Signature of Funeral Service Licensee ▶ [signature]

22. Name and Address of Facility: SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. HYDROMORPHONE INTOXICATION	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	b. Due to (or as a consequence of):	
	c. Due to (or as a consequence of):	
	d. Due to (or as a consequence of):	

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐Yes 2☐No 9☐Unknown

23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown

23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

REMOTE BURNS FROM HOUSEFIRE

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☑Unknown

24a. Was an autopsy performed? 1☑Yes 2☐No

24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☐No

25. Was case referred to medical examiner? ☒1 Yes 2☐No

28. Place of Death (Check only one) Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☐Residence 6☒Other (Specify) AT SCENE

27. Manner of Death 1☐Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☒Could not be determined

28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
3-17-98	unknown M	1☐Yes 2☒No	involved in housefire

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify): apartment building

28f. Location (Street and Number or Rural Route Number, City or Town, State) 16 Pennsylvania Ave. apt. 12, Westminster, MD

29a. Certifier (Check only one) 1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☒ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ [signature]	OCME	MARCH 31, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MARYANN D. KOROLL 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
APR 03 2001	[signature]

To be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 10066

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
John Carl Bell Sr.	March 31, 2001	6:30 A M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Good Samaritan Hospital	Baltimore	N/A

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
212-09-0296	1 M 2 F	89 Yrs.			4/19/1911	Maryland

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	Baltimore	Baltimore	1 Yes 2 No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
1334 Deanwood Road	21234	U.S.A.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1 Never Married 2 Married 3 Widowed 4 Divorced	1 Yes 2 No If Yes, Give Year or Dates:	1 Yes 2 No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	18b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
6		Accounting Clerk	Exxon

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
John Scott Bell	Martha Amelia Ritter

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Charles Bell/Son	148 Switch Point Drive Stewartstown PA. 17363

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)	Moreland Memorial	4/4/01	Baltimore, Maryland

21. Signature of Funeral Service Licensee ▶

22. Name and Address of Facility John C. Miller Inc.
6415 Belair Road Baltimore, Maryland 21206

Physician /Medical Examiner

23e. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Postpartum Intestinal Bleed	few hrs.
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of):	
	c. Due to (or as a consequence of):	
	d. Due to (or as a consequence of):	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month Day Year
1 Yes 2 No 9 Unknown	1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnent at time of death 5 Other (specify) 9 Unknown	

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Congestive Heart Failure
Atrial Fibrillation

23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1 Yes 2 No	1 Yes 2 No

25. Was case referred to medical examiner?	28. Place of Death (Check only one)	
1 Yes 2 No	Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA	Other: 4 Nursing Home 5 Residence 8 Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined		M	1 Yes 2 No	
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1 **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ Barbara Kirsher	D37134	4/2/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Barbara Kirsher MD. 8600 Liberty Road Randallstown MD. 21133

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
APR 0 3 2001	▶ Geneva G Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Medical Certification; To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 28a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 10067

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)			2. Date of Death Month Day Year	3. Time of Death
Peter P. Burnotes			March 28, 2001	12:00 M
4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death	
218 Beaumont Avenue	Catonsville		Baltimore	

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
212-07-5930	X 1 M 2 F	99 Yrs.			09/09/1901	Maryland

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	Baltimore	Catonsville	1 Yes 2 X No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
218 Beaumont Avenue	21228	U.S.A.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1 Never Married 2 Married 3 X Widowed 4 Divorced	1 X Yes 2 No If Yes, Give Year or Dates: WWI	1 Yes 2 X No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
7	0	Mechanic	Automobile

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Joseph Burnotes	Tessie Marker

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Mary T. Lynch-sister	Elmwood Road, Overlea, Maryland, 21206

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)	Most Holy Redeemer	03/31/2001	Baltimore, Maryland

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ Heather A. Brown	Witzke Funeral Home Of Catonsville 1630 Edmondson Avenue, Catonsville, MD., 21228

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Myocardial infarction — Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. _____ Due to (or as a consequence of):

c. _____ Due to (or as a consequence of):

d. _____

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1 Yes 2 X No 9 Unknown

23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify) _____ 9 Unknown

23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Atherosclerotic cardiovascular disease
Hypertension
History cerebrovascular accident

23e. Did tobacco use contribute to the cause of death? 1 Yes 2 X No 3 Probably 4 Unknown

24a. Was an autopsy performed? 1 Yes 2 X No

24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No

25. Was case referred to medical examiner? 1 Yes 2 X No

26. Place of Death (Check only one)
Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA
Other: 4 Nursing Home 5 X Residence 8 Other (Specify)

27. Manner of Death 1 X Natural 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 Yes 2 No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1 X **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ Edmund P. Tkacik	D3495	3-30-01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Edmund P. Tkacik 405 Frederick Rd Ste 100 Catonsville MD 21228

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
APR 03 2001	▶ Geneva G Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Medical Certification; To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 10068

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: WASHINGTON BOWIE, V

2. Data of Death Month Day Yaar: MARCH 29,2001

3. Tima of Death: 12:20P.M

4a. Facility Name *(If not institution, give street and number)*: GREATER BALTIMORE MEDICAL CEN.

4b. City, Town, or Location of Daath: TOWSON

4c. County of Death: BALTIMORE

Funeral Director

5. Social Security Number: 198-05-7272

6. Sex: XX M 2☐ F

7. Aga *(In yrs. last birthday)*: 89 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Data of Birth *(Month, Day, Yaer)*: 12-18-1911

9. Birthplace *(Stata or Foreign Country)*: MARYLAND

Usual Residence of Decedent

10a. Stata: MD.

10b. County: BALTIMORE

10c. City, Town or Location: LUTHERVILLE

10d. Insida City Limits: 1☐ Yas XX No

10e. Street and Number: 1508 BELLONA AVENUE

10f. Zip Code: 21093

10g. Citizan of What Country?: U.S.A.

11. Maritat Status: 1☐ Never Married XX Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Evar in U.S. Armed Forcas? XX Yas 2☐ No If Yes, Giva Yaar or Dates: 1942-1945

13. Was Decadant of Hispanic Origin? (Specify Yas or No- If Yes, specify Cuban, Maxican, Puarto Rican, etc.): 1☐ Yas XX No *Specify:*

14. Raca - American Indian, Black, Whita, etc. *Specify:* WHITE

15. Decedent's Education *(Specify only highast grade completed)*: Elementary/Secondary (0-12): / College (1-4or 5+): 5 YEARS

16a. Decedant's Usual Occupation *(Giva kind of work dona during most of working life. DO NOT usa ratirad)*: CIVIL ENGINEER

16b. Kind of Business/Industry: CONSULTANT ENGINEERING

17. Father's Nama *(First, Middle, Last)*: WASHINGTON BOWIE, JR.

18. Mother's Name *(First, Middla, Maidan Sumama)*: MARION POLLACK JOHNSON

19a. Informant's Name/Relationship *(Type, Print)*: MARY McINTYRE BOWIE (WIFE)

19b. Mailing Address *(Street and Number or Rural Routa Number, City or Town, State, Zip Coda)*: 1508 BELLONA AVENUE,LUTHERVILLE,MD.,21093

20a. Method of Disposition: 1☐ Burial XX Cremation 3☐ Removal from Stata 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Nama of cematery, cramatory or othar place)*: GREEN MOUNT CREM.

Data: 3-31-2001

20c. Location - City or Town, State: BALTIMORE,MD.21202

21. Signature of Funeral Sarvica Licensee: R. D. Rutt

22. Name and Addrass of Facility: HENRY W. JENKINS AND SONS COMPANY 6500 YORK ROAD,BALTIMORE,MARYLAND,21212

Physician /Medical Examiner

23a. Part1. Enter tha diseese, or complications that caused the death. Do not enter the moda of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only ona causa on aach line.

Approximate Interval Between Onsat and Daath

Immediate Cause (Final disease or condition resulting in death)

a. Aspiration pneumonia — 3 days

Dua to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Cerebrovascular accident — 1 week

Due to (or as a consequence of):

c.

Dua to (or as a consequance of):

d.

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1☐ Yes 2☐ No 9☐ Unknown

23c. If yas, outcoma of pregnancy: 1☐ Liva birth 2☐ Fatal daath 3☐ Ectopic pregnancy 4☐ Pregnant at tima of daath 5☐ Othar *(specify)* 9☐ Unknown

23d. Data of dalivary Month Day Year

Part II. **Other significant conditions** contributing to daath but not resulting in the underlying cause given in Part I.: Coronary artery disease

23e. Did tobacco usa contribute to the cause of death? 1☒ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yas XX No

24b. Wara autopsy findings availabla prior to completion of cause of daath? 1☐ Yas 2☐ No

25. Was case referred to medical examiner? 1☐ Yes XX No

28. Place of Death *(Check only one)*: Hospital: XX Inpatient 2☐ ER/Outpatient 3☐ DOA — Othar: 4☐ Nursing Homa 5☐ Rasidanca 6☐ Other *(Specify)*

27. Manner of Death: XX Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be datarmined

28a. Date of Injury *(Month, Day Year)*

28b. Tima of Injury

28c. Injury at Work? 1☐ Yas 2☐ No

28d. Dascriba how injury occurrad

28a. Place of Injury - At homa, farm, streat, factory, office building, etc. *(Specify)*

28f. Location *(Street and Numbar or Rural Routa Number, City or Town, State)*

29a. Certifier *(Check only one)*: XX **Certifying Physician:** To the best of my knowledge, daath occurred at tha tima, date and place, and dua to tha causa(s) and manner as stated. 2☐ **Medical Examiner:** On tha basis of examination and/or investigation, in my opinion, daath occurred at tha tima, date and placa, and due to tha causa(s) and mannar stated.

29b. Signature and title of certifier: F. Wiegmann M.D.

29c. Licensa number: D25569

29d. Data signed *(Month, Day, Yaar)*: MARCH 30,2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): FRANCIS WIEGMANN, M.D., 1205 YORK ROAD,LUTHERVILLE, MARYLAND, 21093

State Registrar

31. Data filed *(Month, Day, Yaar)*: APR 03 2001

32. Registrar's Signature: Jenna B Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Medical Certification; To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 10069

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Regina Katherine Chenworth
2. Date of Death: Month March Day 31, Year 2001
3. Time of Death: 8:45 P M
4a. Facility Name (If not institution, give street and number): Cromwell Nursing Home
4b. City, Town, or Location of Death: Towson
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 214-01-1127
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 87 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Feb.17,1914
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Baltimore
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 4126 Slater Avenue
10f. Zip Code: 21236
10g. Citizen of What Country? United States

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 8 / College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker
16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): August Kollmer
18. Mother's Name (First, Middle, Maiden Surname): Minna Seiler

19a. Informant's Name/Relationship (Type, Print): Doris Alkire/ Daughter
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4126 Slater Avenue Baltimore, MD 21236

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Chesapeake Crematory
Date: 04/03/01
20c. Location - City or Town, State: Beltsville, MD

21. Signature of Funeral Service Licensee: Laura C. Hardesty
22. Name and Address of Facility: CAFA Stephen D. Lohrmann P.A. 8717 Green Pastures Drive Baltimore, MD 21286

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. COPD — Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. — Due to (or as a consequence of):
c. — Due to (or as a consequence of):
d.

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐ Yes 2☒ No 9☐ Unknown
23c. If yes, outcome of pregnancy: 1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) 9☐ Unknown
23d. Date of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
CHF COPD Chronic Atrial fibrillation
DJD Depression Early Dementia

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown
24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
28. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification; To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Martha C. Raymundo, MD
29c. License number: D54518
29d. Date signed (Month, Day, Year): 4/1/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Martha C. Raymundo 3007 E. Northern parkway Baltimore, MD 21214

State Registrar

31. Date filed (Month, Day, Year): APR 03 2001
32. Registrar's Signature: Jeanne G Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 10070

Callaway, Thomas

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death (Month, Day, Year)	3. Time of Death
THOMAS E CALLAWAY	April 01, 2001	6:23pm

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Franklin Square Hospital Center	Rosedale	Baltimore

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
212-56-8002	1☒ M 2☐ F	51 Yrs.			Dec. 9 1949	SouthCarolina

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	Baltimore	Rosedale	1☐ Yes 2☒ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
800 Rosedale Ave.	21237	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced	1☐ Yes 2☒ No If Yes, Give Year or Dates:	1☐ Yes 2☒ No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
9th		Custodian	Baltimore County

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Francis Blum	Madeline Bumgartner

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Carol Callaway / wife	800 Rosedale Ave. Baltimore MD 21237

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)	Oaklawn Cemetery	4/5/01	Baltimore MD

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ R. Terry Connelly	Connelly Funeral Home of Essex 300 Mace Ave. Baltimore MD 21221

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Non-Hodgkins Lymphoma	3years
	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	b.	
	Due to (or as a consequence of):	
	c.	
	Due to (or as a consequence of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Chronic Obstructive Pulmonary Disease
Acute Renal Failure
Acute Respiratory Failure

23b. Did tobacco use contribute to the cause of death? 1☑ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐ Yes 2☑ No	1☐ Yes 2☐ No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐ Yes 2☑ No	Hospital: 1☑ Inpatient 2☐ ER/Outpatient 3☐ DOA	Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined		M	1☐ Yes 2☐ No	
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ Stuart R. Willes MD	D36663	04/01/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Dr. Stuart R. Willes 9000 Franklin Square Drive Baltimore, MD 21237

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
APR 03 2001	Donna G Sparks

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 16 Rev 6/95

ORIGINAL

01-1692-510
CJ
Edsel F. Crawford

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

1- For State Registrar

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 10071

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month	Day	Year	3. Time of Death
Edsel Ford Crawford	March	27	2001	11:05 A.M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
University of Maryland Shock Trauma	Baltimore	N/A

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year Months	If Under 1 Year Days	If Under 24 Hrs. Hours	If Under 24 Hrs. Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
407-22-8082	1☒M 2☐F	77 Yrs.					OCT 15, 1923	Kentucky

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Anne Arundel	Hanover	1☐Yes 2☒No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
7303 Forest Avenue	21076	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐Never Married 2☐Married 3☒Widowed 4☐Divorced	1☒Yes 2☐No If Yes, Give Year or Dates:	1☐Yes 2☒No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12		Manager	Arcade

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Joe Crawford	Emma Ruth Fields

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Clarence Crawford/Brother	7624 Buena Vista Court, Louisville, KY 40219

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☐Burial 2☒Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	Metro Crematory, Inc.	3-30-01	Baltimore, MD

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
Edward A. Gregorchik	Cremation Society of MD, Inc. 299 Frederick Road Baltimore, MD 21228

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. HEAD, NECK, AND CHEST INJURIES IN ASSOCIATION WITH	
Due to (or as a consequence of):	METASTATIC COLON CANCER	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of):	
	c. Due to (or as a consequence of):	
	d.	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month Day Year
1☐Yes 2☐No 9☐Unknown	1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

HYPERTENSIVE CARDIOVASCULAR DISEASE

23e. Did tobacco use contribute to the cause of death?	24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐Yes 2☒No 3☐Probably 4☐Unknown	1☒Yes 2☐No	1☒Yes 2☐No

25. Was case referred to medical examiner?	28. Place of Death (Check only one)
1☒Yes 2☐No	Hospital: 1☐Inpatient 2☒ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☐Residence 8☐Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☐Natural 2☒Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined	3/26/01	2203 M	1☐Yes 2☒No	DRIVER OF A CAR WHICH STRUCK A FIXED OBJECT
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) ROADWAY			28f. Location (Street and Number or Rural Route Number, City or Town, State) 2900 BLOCK JESSUP RD, JESSUP, MD

Medical Certification; To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one)
1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☒ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
M.D.	O.C.M.E.	March 28, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
MARY G. RIPPLE, M.D., 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
APR 03 2001	Geneva G Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23e or 28a-i show any injury or other traumatic event, the Medical Examiner must be notified at once.

To be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 10072

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
Donald E. Cole	March 22 2001	4:00 P M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
902 Bernoudy Road	White Hall	Baltimore

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
217-24-5371	1☐M 2☐F	72 Yrs.			Feb. 9 1929	Maryland

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	Baltimore	White Hall	1☐Yes 2☒No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
902 Bernoudy Road	21161	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐Never Married 2☒Married 3☐Widowed 4☐Divorced	1☒Yes 2☐No If Yes, Give Year or Dates: '45-'48	1☐Yes 2☒No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12	n/a	Fire Fighter	Paid Fireman

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Samuel Parkin Cole	Anna Elizabeth Thacker

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Elizabeth A. Cole/wife	902 Bernoudy Rd., White Hall, MD 21161

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	St. James Episcopal Church Cemetery	3/27/01	Monkton, MD

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
Michael J. Flagle	Lemmon Funeral Home 10 W. Padonia Rd., Timonium, MD 21093

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

Medical Certification; To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. END Stage Heart Failure.	Years
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of): b. End Stage Renal Failure	Years
	Due to (or as a consequence of): c. Left Ventricular Dysfunction	Years
	Due to (or as a consequence of): d.	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month Day Year
1☐Yes 2☐No 9☐Unknown	1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☒Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐Yes 2☒No	1☐Yes 2☒No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐Yes 2☑No	Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA	Other: 4☐Nursing Home 5☒Residence 6☐Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined		M	1☐Yes 2☐No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to tha cause(s) and manner stated.

29b. Signature and title of certifier	29c. Licanse number	29d. Date signed (Month, Day, Yeer)
Frank Morris MD	D0d 8406	3/30/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Frank Morris, M.D. 7505 Osler Dr., Suite 103 Towson, MD 21204

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
APR 03 2001	Rebecca G Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 10073

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): BETTY CARP

2. Date of Death (Month, Day, Year): MARCH 31, 2001

3. Time of Death: 6:36 AM

4a. Facility Name (If not institution, give street and number): NORTHWEST HOSPITAL CENTER

4b. City, Town, or Location of Death: RANDALLSTOWN

4c. County of Death: BALTIMORE

Funeral Director

5. Social Security Number: 218-32-0739

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 85 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): MAY 4, 1915

9. Birthplace (State or Foreign Country): N.Y.

Usual Residence of Decedent

10a. State: MD

10b. County: BALTIMORE

10c. City, Town or Location: BALTIMORE

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 3 TROTTERS COURT

10f. Zip Code: 21208

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married ☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): | College (1-4or 5+): 4

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): TEACHER

16b. Kind of Business/Industry: EDUCATION

17. Father's Name (First, Middle, Last): BENJAMIN RUBIN

18. Mother's Name (First, Middle, Maiden Surname): ROSE YATEMAN

19a. Informant's Name/Relationship (Type, Print): JUDY RUDO / DAUGHTER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 26 STABLEMERE COURT - BALTIMORE, MD 21209

20a. Method of Disposition: ☒ 1 Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): HEBREW FRIENDSHIP CEM.

Date: 4/1/01

20c. Location - City or Town, State: BALTIMORE, MD

21. Signature of Funeral Service Licensee: Robert Fine

22. Name and Address of Facility: SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. CORONARY ARTERY DISEASE — YEARS

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: GASTROINTESTINAL BLEED

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☒ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: MD

29c. License number: D47587

29d. Date signed (Month, Day, Year): APRIL 2, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): ROBERT FINE, MD 5401 OLD COURT ROAD, RANDALLSTOWN, MD 21133

State Registrar

31. Date filed (Month, Day, Year): APR 03 2001

32. Registrar's Signature: B Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If Item 27 is marked other than 'natural', or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified as soon as possible.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

1- For State Registrar

Reg. No. 2001 10074

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): DANIEL C. CZAWLYTKO
2. Date of Death (Month, Day, Year): MARCH 26, 2001
3. Time of Death: 9:51 AM
4a. Facility Name (If not institution, give street and number): Saint Joseph Medical Center
4b. City, Town, or Location of Death: Towson
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 213-16-5236
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 79 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 8/31/21
9. Birthplace (State or Foreign Country): MD

Usual Residence of Decedent

10a. State: MD
10b. County: BALTIMORE
10c. City, Town or Location: BALTIMORE
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 1200 HILLSHIRE RD.
10f. Zip Code: 21222
10g. Citizen of What Country: USA

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Yeer or Dates: WWII
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Rece - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondery (0-12): 12 | College (1-4or 5+): 0
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): SAW FILER
18b. Kind of Business/Industry: GLENN L. MARTIN

17. Father's Name (First, Middle, Last): JOHN CZAWLYTKO
18. Mother's Name (First, Middle, Meiden Surneme): HENRIETTA CIESLA

19a. Informant's Name/Relationship (Type, Print): EDWINA CZAWLYTKO/ WIFE
19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code): 1200 HILLSHIRE RD. BALTO., MD. 21222

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Neme of cemetery, crematory or other piece): ST. STANISLAUS
Date: 3/30/01
20c. Location - City or Town, State: BALTIMORE, MD.

21. Signature of Funeral Service Licensee: Charles Kaczorowski
22. Name and Address of Facility: kaczorowski funeral home p.a. 1201 DUNDALK AVE. BALTO., MD. 21222

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiec or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximete Intervel Between Onset and Death

Immediate Cause (Finel disease or condition rasulting in death)
a. SEPTIC SHOCK — 12-24 HOURS

Due to (or as e consequence of):

Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Diseese or injury that initieted events resulting in death) Last
b. INTRA ABDOMINAL SEPSIS

Due to (or as a consequence of):
c. ACUTE RENAL FAILURE

Due to (or as e consequence of):
d. RESPIRATORY FAILURE

IF FEMALE:
23b. Wes decedent pregnant in the pest 12 months? 1 [ ] Yes 2 [ ] No 9 [ ] Unknown
23c. If yes, outcome of pregnancy 1 [ ] Live birth 2 [ ] Fetal death 3 [ ] Ectopic pregnancy 4 [ ] Pregnent at time of death 5 [ ] Other (specify) 9 [ ] Unknown
23d. Date of delivery (Month, Day, Year)

Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was en autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Wes case referred to medical exeminer? 1 [ ] Yes 2 [X] No

28. Place of Death (Check only one)
Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA
Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Menner of Deeth: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day Yeer)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rurel Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1 [X] Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end manner as stated. 2 [ ] Medicat Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) and manner stated.

29b. Signature and title of certifier: H. Neal Reynolds
29c. License number: D 27163
29d. Date signed (Month, Day, Yeer): 3/27/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): H. NEAL REYNOLDS, M.D. 7601 OSLER DRIVE TOWSON, MARYLAND 21204

State Registrar

31. Date filed (Month, Day, Year): APR 03 2001
32. Registrar's Signature: Irene G. Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Medical Certification; To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 10075

Davenport, Lois

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Lois Claire Davenport
2. Date of Death (Month, Day, Year): March 31, 2001
3. Time of Death: 3:45 am
4a. Facility Name *(If not institution, give street and number)*: Franklin Square Hospital Center
4b. City, Town, or Location of Death: Rosedale
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 216-20-7037
6. Sex: 1☐M 2☒F
7. Age *(In yrs. last birthday)*: 75 Yrs. (If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.)
8. Date of Birth *(Month, Day, Year)*: Feb. 7, 1926
9. Birthplace *(State or Foreign Country)*: Florida

Usual Residence of Decedent

10e. State: MD
10b. County: N/A
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1☒Yes 2☐No
10e. Street and Number: 4607 Kenwood Avenue
10f. Zip Code: 21206
10g. Citizen of What Country?: USA

11. Marital Status: 1☐Never Married 2☐Married 3☐Widowed 4☒Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐Yes 2☒No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐Yes 2☒No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* BLACK

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12th; College (1-4or 5+): +1
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Teacher
16b. Kind of Business/Industry: Baltimore City Public Schools

17. Father's Name *(First, Middle, Last)*: Lindsey Solomon
18. Mother's Name *(First, Middle, Maiden Surname)*: Angeline Mim

19a. Informant's Name/Relationship *(Type, Print)*: Gail D. Hom-Parke-daughter
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 5 Libra Ct. Baltimore, Maryland 21237

20a. Method of Disposition: 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Arbutus Mem. Pk. Cem.
Date: 04/06
20c. Location - City or Town, State: Balto. MD

21. Signature of Funeral Service Licensee: Ernest R. Nutter Jr.
22. Name and Address of Facility: Nutter Funeral Homes, Inc. 2501 Gwynns Falls Pkwy. Balto. MD 21216

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death):
a. Cerebral hemorrhage — 1 day
Due to (or as a consequence of):
b. Hypertension — years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Dementia (type 2)

23b. Did tobacco use contribute to the cause of death? 1☐Yes 2☑No 3☐Probably 4☐Unknown

24a. Was an autopsy performed? 1☐Yes 2☑No
24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☐No

25. Was case referred to medical examiner? 1☐Yes 2☑No
26. Place of Death *(Check only one)*: Hospital: 1☑Inpatient 2☐ER/Outpatient 3☐DOA; Other: 4☐Nursing Home 5☐Residence 6☐Other *(Specify)*

27. Manner of Death: 1☑Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined
28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury
28c. Injury at Work? 1☐Yes 2☐No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☐**Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated. 2☐**Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: W Agate
29c. License number: RD 189142
29d. Date signed *(Month, Day, Year)*: March 31, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Dr. W. Agate 9000 Franklin Square Dr. Baltimore, Maryland 21237

State Registrar

31. Date filed *(Month, Day, Year)*: APR 03 2001
32. Registrar's Signature: Brenda G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 10076

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Tawana Davis

2. Date of Death Month / Day / Year: March 30, 2001

3. Time of Death: 14:20pm

4a. Facility Name *(If not institution, give street and number)*: Johns Hopkins Hospital

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: NA

Funeral Director

5. Social Security Number: 140-66-5636

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 27 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: 03-30-73

9. Birthplace *(State or Foreign Country)*: NJ

Usual Residence of Decedent

10a. State: MD

10b. County: NA

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 1213 E. Federal Street

10f. Zip Code: 21202

10g. Citizen of What Country?: USA

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Datas:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* Black

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12th Grade | College (1-4or 5+): NA

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Clerk

16b. Kind of Business/Industry: Company

17. Father's Name *(First, Middle, Last)*: Bill Murray, Sr.

18. Mother's Name *(First, Middle, Maiden Surname)*: Leverne Corbert

19a. Informant's Name/Relationship *(Type, Print)*: Bill Murray, Sr.

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 63 Cleremont Avenue Irivington, NJ 07111

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Voshell Mem. Gardens

Date: 04-04-01

20c. Location - City or Town, State: Dundalk, MD

21. Signature of Funeral Service Licensee: ▶ Gladys Warner

22. Name and Address of Facility: Baltimore, Maryland 21202 WM.C.March FH 1101 E. North Avenue

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): e. metastatic breast cancer — 5 years

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☒ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day, Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ [signature] MD

29c. License number: D40854

29d. Date signed *(Month, Day, Year)*: 4/2/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): David Rusbergs 301 St Paul Place Baltimore 21202

State Registrar

31. Date filed *(Month, Day, Year)*: APR 0 3 2001

32. Registrar's Signature: ▶ Geneva G Scarks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 10077

DORIS DOVEL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): DORIS R DOVEL

2. Date of Death (Month, Day, Year): March 31, 2001

3. Time of Death: 11:35 pm

4a. Facility Name (If not institution, give street and number): Maryland General Hospital

4b. City, Town, or Location of Death: Baltimore City

4c. County of Death: N/A

Funeral Director

5. Social Security Number: 212-16-3500

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 83 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Dec. 12, 1917

9. Birthplace (State or Foreign Country): Maryland

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: MD

10b. County: Baltimore

10c. City, Town or Location: Essex

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 347 Stillwater Road

10f. Zip Code: 21221

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 5th

College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker

16b. Kind of Business/Industry: own home

17. Father's Name (First, Middle, Last): Roland Collison

18. Mother's Name (First, Middle, Maiden Surname): Anna

19a. Informant's Name/Relationship (Type, Print): Shirley Fitch / daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 347 Stillwater Road Baltimore MD 21221

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Meadowridge Memorial

Date: 4/4/01

20c. Location - City or Town, State: Baltimore MD

21. Signature of Funeral Service Licensee: R. Terry Connelly

22. Name and Address of Facility: Connelly Funeral Home of Essex 300 Mace Ave. Baltimore Md. 21221

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Respiratory Failure

Due to (or as a consequence of):

b. Arteriosclerotic Cardiovascular Disease

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c. Pneumonia

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death (Check only one)

Hospital: 1☑ Inpatient 2☐ ER/Outpatient 3☐ DOA

Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Maryam Soumai, MD 3/31/01

29c. License number: P13533

29d. Date signed (Month, Day, Year): March 31, 2001

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): Maryam Soumai M.D. c/o Maryland General Hospital

State Registrar

31. Date filed (Month, Day, Year): APR 03 2001

32. Registrar's Signature: Emma G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death Reg. No. 2001 10078

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Arnette Mary Duvall
2. Date of Death Month Day Year: April 2, 2001
3. Time of Death: 4:00 AM
4a. Facility Name *(If not institution, give street and number)*: Crofton Convalescence Center
4b. City, Town, or Location of Death: Crofton
4c. County of Death: Anne Arundel

Funeral Director

5. Social Security Number: 219-10-9413
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 77 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: SEPT 13, 1923
9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Anne Arundel
10c. City, Town or Location: Severn
10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 674 Donaldson Avenue
10f. Zip Code: 21144
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 8 | College (1-4or 5+):
18a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Homemaker
16b. Kind of Business/Industry: Own Home

17. Father's Name *(First, Middle, Last)*: Richard Ellard
18. Mother's Name *(First, Middle, Maiden Surname)*: Hilda Mason

19a. Informant's Name/Relationship *(Type, Print)*: Diana Easton/Daughter
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 1083 Dicus Mill Road Millersville, MD 21108

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Metro Crematory Inc.
Date: 4-3-01
20c. Location - City or Town, State: Baltimore, MD

21. Signature of Funeral Service Licensee: Thomas Gregor
22. Name and Address of Facility: Cremation Society of MD, Inc. 299 Frederick Road Baltimore, MD 21228

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death): a. Alzheimers disease — Approximate Interval Between Onset and Death: 3 years

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Diabetes, Dyslipidemia

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: MD
29c. License number: D 38958
29d. Date signed *(Month, Day, Year)*: 4/2/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Daljeet Singh Sidhu 1413 Annapolis Road #106 odenton MD 21113

State Registrar

31. Date filed *(Month, Day, Year)*: APR 03 2001
32. Registrar's Signature: B Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 10079

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Bertha L. Dodson

2. Date of Death Month Day Year: March 30, 2001

3. Time of Death: 2:08 PM

4a. Facility Name (If not institution, give street and number): Carroll County General Hospital

4b. City, Town, or Location of Death: Westminister

4c. County of Death: Carroll

Funeral Director

5. Social Security Number: 215-05-4516

6. Sex: 1☐M 2☒F

7. Age (In yrs. last birthday): 85 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): 1/21/1916

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: MD

10b. County: Carroll

10c. City, Town or Location: Sykesville

10d. Inside City Limits: 1☐Yes 2☒No

10e. Street and Number: 1840 Bennett Road

10f. Zip Code: 21784

10g. Citizen of What Country? U.S.A.

11. Marital Status: 1☐Never Married 2☐Married 3☒Widowed 4☐Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐Yes 2☒No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 12

College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker

16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): James Scott

18. Mother's Name (First, Middle, Maiden Surname): Bertha Engelbach

19a. Informant's Name/Relationship (Type, Print): Brenda Saunders/Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4403 Parkmont Avenue Baltimore, Maryland 21206

20a. Method of Disposition: 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donetion 5☐Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Parkwood Cemetery

Date: 4/4/01

20c. Location - City or Town, State: Baltimore, Maryland

21. Signature of Funeral Service Licensee:

22. Name and Address of Facility: John C. Miller Inc. 6415 Belair Road Baltimore, Maryland 21206

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. sudden cardiac death — 5min

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. idiopathic dilated cardiomyopathy — 5yrs

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1☐Yes 2☐No 9☐Unknown

23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetel death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown

23d. Date of delivery Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☐Unknown

24a. Was an autopsy performed? 1☐Yes 2☐No

24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☐No

25. Was case referred to medical examiner? 1☐Yes 2☐No

28. Place of Death (Check only one)

Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA

Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death: 1☐Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work? 1☐Yes 2☐No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☐Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: MD

29c. License number: D39296

29d. Date signed (Month, Day, Year): 4/1/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): R. Ricketts MD CCGH Westminster MD 21157

State Registrar

31. Date filed (Month, Day, Year): APR 03 2001

32. Registrar's Signature: Geneva G Sparks

DHMH 17 Rev 1/2001

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 10080

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): AGNES , DORISH
2. Date of Death: Month March, Day 31, Year 2001
3. Time of Death: 1:05 p.m.
4a. Facility Name (If not institution, give street and number): Harbor Hospital Center
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 212-74-8223
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 92 Yrs. | If Under 1 Year: Months, Days | If Under 24 Hrs.: Hours, Min.
8. Date of Birth (Month, Day, Year): MARCH 18, 1909
9. Birthplace (State or Foreign Country): WV

Usual Residence of Decedent

10a. State: MARYLAND
10b. County: ANNE ARUNDEL
10c. City, Town or Location: GLEN BURNIE
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 6652 ROBERTS COURT, APT. B 112
10f. Zip Code: 21061
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 6; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): HOMEMAKER
16b. Kind of Business/Industry: OWN HOME

17. Father's Name (First, Middle, Last): ANTHONY MARCHLINUS
18. Mother's Name (First, Middle, Maiden Surname): MARY BERNOSKI

19a. Informant's Name/Relationship (Type, Print): MRS. MARY M. JONES (DAUGHTER)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 12 MANCHESTER ROAD, PASADENA, MARYLAND 21122

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): HOLY CROSS CEMETERY
Date: APRIL 3, 2001
20c. Location - City or Town, State: BALTIMORE, MARYLAND

21. Signature of Funeral Service Licensee: [signature] MD795
22. Name and Address of Facility: SINGLETON FUNERAL HOME, P.A., 1 SECOND AVENUE, S.W., GLEN BURNIE, MD. 21061

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) a.	Cardiogenic Shock	72 hours
Due to (or as a consequence of): b.	Myocardial Infarction	5 days
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last — Due to (or as a consequence of): c.		
Due to (or as a consequence of): d.		

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Hypertension
Atrial fibrillation with Pacemaker

23b. Did tobacco use contribute to the cause of death? 1☑ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No
26. Place of Death (Check only one): Hospital: 1☑ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: Kourosh Dibaj, M.D.
29c. License number: Res001
29d. Date signed (Month, Day, Year): March, 31, 2001
30. Name and address of person who completed cause of death (Item 23e) (Type, Print): KOUROSH DIBAJ, 3001 South Hanover Street, Baltimore, MD 21225

State Registrar

31. Date filed (Month, Day, Year): APR 03 2001
32. Registrar's Signature: [signature]

ORIGINAL

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

AMEND ITEM: 9

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar AMENDED ITEM 10b per fh G794 042601 SS

Certificate of Death

Reg. No. 2001 10081

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)			2. Date of Death Month / Day / Year	3. Time of Death
MARY STEVENSON DIXON			MARCH 28, 2001	12:15 A M
4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death	
FREDERICK MEMORIAL HOSPITAL	FREDERICK		FREDERICK	

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
220-07-4073	1☐M 2☒F	86 Yrs.			10/25/1914	MARYLAND

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	~~FREDERICK~~ CARROLL	MT. AIRY	1☐Yes 2☒No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
4101 OLD NATIONAL PIKE	21771	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐Never Married 2☐Married 3☒Widowed 4☐Divorced	1☐Yes 2☒No If Yes, Give Year or Dates:	1☐Yes 2☒No Specify:	Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12		SECRETARY	SECRETARY

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
DAVID HAYS STEVENSON	GRACE THOMAS SUMMERS

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
FRANCES STEVENSON(NIECE)	2724 ORDWAY ST. N.W. APT. 4 WASH.,D.C. 20008.

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	GREEN MOUNT	04/02/2001	BALTO.CITY,MD.

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
William C. Davis III	HENRY W. JENKINS & SONS CO. 6500 YORK RD. BALTO.,MD. 21212.

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified as soon as possible.

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. LEFT Pneumonia	2 WKS
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of):	
	c. Due to (or as a consequence of):	
	d. Due to (or as a consequence of):	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month / Day / Year
1☐Yes 2☒No 9☐Unknown	1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

atrial fibrillation
Congestive heart failure

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐Yes 2☒No	1☐Yes 2☐No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐Yes 2☒No	Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA	Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined		M	1☐Yes 2☐No	
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)	

Medical Certification; To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

29a. Certifier (Check only one)	
1☒	**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐	**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
Allen J. Gilson MD	D26576	MARCH 28 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Allen J. Gilson MD 1475 TANEY AVE FREDERICK MD 21702

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
APR 03 2001	Geneva G Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 10082

ISABEL DAVIS

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
Isabel Thom Barton Davis	March 29 2001	5:00PM M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Blakehurst	Towson	Baltimore

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
214-34-2799	1☐M 2☒F	81 Yrs.			June 19 1919	Maryland

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Md.	Baltimore	Towson	1☐Yes 2☒No

10e. Street and Number	10f. Zip Code	10g. Citizen of Whel Country?
1055 W. Joppa Rd.	21204	USA

11. Maritel Stetus	12. Wes Decedent Ever in U.S. Armed Forces?	13. Wes Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Rece - American Indian, Black, White, etc.
1☐Never Married 2☐Married 3☒Widowed 4☐Divorced	1☐Yes 2☒No If Yes, Give Year or Detes:	1☐Yes 2☒No Specify:	Specify: White

15. Decedent's Education (Specify only highest grede completed)		16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
	+6	Teacher	Education

17. Fether's Neme (First, Middle, Last)	18. Mother's Neme (First, Middle, Meiden Surname)
Carlyle Barton	Isabel Thom

19a. Informant's Name/Reletionship (Type, Print)	19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code)
Mr. Aldrich Davis/ Son	3694 Ashley Way Owings Mills, Md. 21117

20e. Method of Disposition	20b. Place of Disposition (Name of cemetery, cremetory or other piece)	Dete	20c. Location - City or Town, Stete
1☐Burial 2☒Cremation 3☐Removel from Stete 4☐Donation 5☐Other (Specify)	Hilltop Service Co.	4-02-2001	Towson, Md.

21. Signature of Funeral Service Licensee ▶ [signature]

22. Neme and Address of Feciility: Ruck Towson Funeral Home, Inc. 1050 York Rd. Towson, Md. 21204

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part1. Enter the disease, or complicetions that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset end Deeth

Immediate Cause (Finel disease or condition resulting in deeth)

a. dispathic pulmonary fibrosis — Due to (or as e consequence of): — ~5 years

Sequentially list conditions, if any, leeding to immediete cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in deeth) Last

b. — Due to (or es a consequence of):

c. — Due to (or as e consequence of):

d.

IF FEMALE:

23b. Wes decedent pregnant in the pest 12 months? 1☐Yes 2☑No 9☐Unknown

23c. If yes, outcome of pregnency: 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnent at time of death 5☐Other (specify) 9☐Unknown

23d. Date of delivery Month Day Year

Pert II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Pert I.

aspiration pneumonitis
depression
congestive heart failure

23e. Did tobecco use contribute to the cause of deeth? 1☐Yes 2☑No 3☐Probably 4☐Unknown

24a. Was an autopsy performed? 1☐Yes 2☑No

24b. Were autopsy findings available prior to completion of cause of deeth? 1☐Yes 2☑No

25. Wes case refeited to medical exeminer? 1☐Yes 2☑No

26. Place of Deeth (Check only one): Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☑Nursing Home 5☐Residence 6☐Other (Specify)

27. Menner of Deeth: 1☑Neturel 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigetion 6☐Could not be determined

28a. Dete of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury et Work? 1☐Yes 2☐No

28d. Describe how injury occurred

28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify)

28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1☑**Certifying Physician:** To the best of my knowledge, death occurred et the time, date end place, end due to the cause(s) end menner as steted. 2☐**Medical Examiner:** On the besis of exeminetion and/or investigation, in my opinion, deeth occurred et the time, date end place, end due to the cause(s) end menner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Dey, Year)
▶ Bruce Rosenberg	D24121	3/30/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): BRUCE ROSENBERG 21 WEST RD TOWSON, MD 21204

State Registrar

31. Date filed (Month, Dey, Yeer)	32. Registrar's Signature
APR 03 2001	▶ Barbara G Sparks

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No: 2001 10083

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): CATHERINE E. DENHAM
2. Date of Death Month: APRIL Day: 1 Year: 2001
3. Time of Death: 345 PM
4a. Facility Name (If not institution, give street and number): GENESIS ELDERCARE LONG GREEN
4b. City, Town, or Location of Death: BALTIMORE
4c. County of Death: NA

Funeral Director

5. Social Security Number: 216-44-2257
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 92 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Oct 3 1908
9. Birthplace (State or Foreign Country): Md.

Usual Residence of Decedent

10a. State: Md
10b. County: NA
10c. City, Town or Location: BALTIMORE
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 1814 SWANSEA ROAD
10f. Zip Code: 21239
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No — If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 — College (1-4or 5+): NA
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): HOMEMAKER
16b. Kind of Business/Industry: HOME

17. Father's Name (First, Middle, Last): HENRY CRUMHOLTZ
18. Mother's Name (First, Middle, Maiden Surname): CATHERINE B. MIHM

19a. Informant's Name/Relationship (Type, Print): WALLACE A. DENHAM
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1814 SWANSEA Rd, BALTo Md. 21239

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): ROCK RUN CEM. — Date: 4/4/01
20c. Location - City or Town, State: HARFORD Co.

21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: HARTLEY MILLER FUNERAL HOME, CHTD. 7527 Harford Rd Balto Md 21234

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Fever and Dehydration — days
Due to (or as a consequence of):
b. Senile Dementia — years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Arteriosclerotic Coronary Artery Disease
Peripheral Vascular Disease

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: [signature] MD
29c. License number: D17118
29d. Date signed (Month, Day, Year): Apr 2, 2001
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Paul Schwartz M.D. 7700 York Rd 21204

State Registrar

31. Date filed (Month, Day, Year): APR 03 2001
32. Registrar's Signature: [signature] G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 10084

CLARENCE A. EVANS

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Clarence Aster Evans Jr.

2. Date of Death: Month MARCH Day 30 Year 2001

3. Time of Death: 12:15 AM

4a. Facility Name (If not institution, give street and number): GREATER BALTIMORE MEDICAL CENTER

4b. City, Town, or Location of Death: TOWSON

4c. County of Death: BALTIMORE

Funeral Director

5. Social Security Number: 220-36-0825

6. Sex: 1☐ M 2☐ F — X

7. Age (In yrs. last birthday): 61 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): 09-27-1939

9. Birthplace (State or Foreign Country): Virginia

Usual Residence of Decedent

10a. State: Md.

10b. County: N/A

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 1311 East Northern Parkway

10f. Zip Code: 21239

10g. Citizen of What Country? USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☒ Yes 2☐ No — If Yes, Give Year or Dates: Army 8/1968

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☒ Yes 2☐ No Specify:

14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 7 th; College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Longshoreman

16b. Kind of Business/Industry: Steamship Trade Assoc.

17. Father's Name (First, Middle, Last): Clarence Aster Evans Sr.

18. Mother's Name (First, Middle, Maiden Surname): Emma Jane Goldston

19a. Informant's Name/Relationship (Type, Print): Timberly Johnson (Daughter)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 6213 Hilltop Ave. Balto., Md. 21206

20a. Method of Disposition: 1☒ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetary, crematory or other place): Metro - Garrison Forest

Date: 4-5-01

20c. Location - City or Town, State: Owings Mills, Md.

21. Signature of Funeral Service Licensee: Dennis B. Caple

22. Name and Address of Facility: Dennis B. Caple Funeral Home P.A. 4601 York Rd. Balto., Md. 21212

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. METASTATIC RENAL CELL CARCINOMA

Due to (or as a consequence of): b. SEPTICEMIA

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of): c. RESPIRATORY FAILURE

Due to (or as a consequence of): d. CANCER OF THE LUNG

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☒ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Raymond Allen MD

29c. License number: D34184

29d. Date signed (Month, Day, Year): 3/30/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Raymond Allen 7801 YORK RD #100, TOWSON MD 21204

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

State Registrar

31. Date filed (Month, Day, Year): APR 03 2001

32. Registrar's Signature: Barbara G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 10085

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)			2. Date of Death Month Day Year	3. Time of Death
KATHY	LYNN	FRENCH	MARCH 27, 2001	5:45 AM M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
NORTH ARUNDEL HOSPITAL ASSOCIATION	GLEN BURNIE	ANNE ARUNDEL

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Yeer)	9. Birthplece (State or Foreign Country)
265-63-8811	1☐M 2☒F	42 Yrs.			FEB. 26, 1959	CA

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MARYLAND	ANNE ARUNDEL	SEVERN	1☐Yes 2☒No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
8016 MILLSTONE COURT	21144	U.S.A.

11. Marital Status	12. Wes Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Rece - American Indian, Bleck, White, etc.
1☐Never Married 2☒Married 3☐Widowed 4☐Divorced	1☐Yes 2☒No If Yes, Give Yeer or Detes:	1☐Yes 2☒No Specify:	Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12		HOMEMAKER	OWN HOME

17. Father's Name (First, Middle, Last)		18. Mother's Name (First, Middle, Maiden Surname)	
RICHARD	SCHAEFER	JOANNE	LEICHTMAN

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
MR. GARY FRENCH (HUSBAND)	8016 MILLSTONE COURT, SEVERN, MD. 21144

20a. Method of Disposition	20b. Piece of Disposition (Name of cemetery, crematory or other piece)	Date	20c. Location - City or Town, State
1☒Burial 2☐Cremation 3☐Removet from State 4☐Donation 5☐Other (Specify)	ARLINGTON NATIONAL CEMETERY	3/30/2001	ARLINGTON, VIRGINIA

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
	SINGLETON FUNERAL HOME, P.A. 1 SECOND AVENUE, S.W., GLEN BURNIE, MARYLAND 21061

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Finat disease or condition resulting in death)	e. Asystole due to myocardial infarction	hours
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of): Staph aureus bacteremia and pneumonia	1 week
	c. Due to (or as a consequence of): infected dialysis graft	1 week
	d. Due to (or as a consequence of):	

IF FEMALE: 23b. Was decedent pregnent in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month Day Year
1☐Yes 2☒No 9☐Unknown	1☐Live birth 2☐Fetal death 3☐Ectopic pregnency 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Anoxic encephalopathy, hypertension
Chronic dialysis, hypothyroidism
Bipolar illness

23e. Did tobecco use contribute to the cause of death?	24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐Yes 2☐No 3☐Probably 4☒Unknown	1☐Yes 2☒No	1☐Yes 2☒No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐Yes 2☒No	Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA	Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

Medical Certification; To Be Completed by Physician/Medical Examiner

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work?	28d. Describe how injury occurred
1☒Naturat 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined			1☐Yes 2☐No	

28e. Place of Injury - At home, term, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date end piece, and due to the cause(s) end menner as stated.
2☐**Medical Examiner:** On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date and place, end due to the ceuse(s) and manner stated.

29b. Signature and title of certifier	29c. Licanse number	29d. Date signed (Month, Day, Yeer)
Bayinnah Shabazz MD	D24592	March 27, 2001

30. Name and address of person who completed cause of death (Item 29a) (Type, Print)
DR. BAYINNAH SHABAZZ, M.D., 1406 CRAIN HIGHWAY, SUITE 206, GLEN BURNIE, MD. 21061

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
APR 0 3 2001	G Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23e or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Replacement

Reg. No. 2001 10086

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Lillian L. Ford

2. Date of Death (Month, Day, Year): March 14, 2001

3. Time of Death: 9:22 PM

4e. Facility Name (If not institution, give street and number): Crofton Convalescent Home

4b. City, Town, or Location of Death: Crofton

4c. County of Death: Anne Arundel

Funeral Director

5. Social Security Number: 193-12-4721

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 78 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Jan.4,1923

9. Birthplace (State or Foreign Country): Pennsylvania

Usual Residence of Decedent

10a. Stete: MD

10b. County: Prince George

10c. City, Town or Location: Laurel

10d. Inside City Limits: 1☐ Yes 2☒ No

10a. Street and Number: 11913 Orvis Way

10f. Zip Code: 20708

10g. Citizen of What Country?: USA

11. Meritel Stetus: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Wes Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Detes:

13. Wes Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementery/Secondery (0-12): 12

College (1-4or 5+): Ø

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker

16b. Kind of Business/Industry: Own Home

17. Fether's Neme (First, Middle, Last): Prokop Ladyn

18. Mother's Name (First, Middle, Maiden Surname): Anna Polak

19a. Informant's Neme/Reletionship (Type, Print): Edward Ford/Husband

19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 11913 Orvis Way, Laurel, Maryland 20708

20e. Method of Disposition: 1☒ Burial 2☐ Cremetion 3☐ Removel from State 4☐ Donetion 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, cremetory or other piece): Arlington National Cem. Date: 3/21/01

20c. Location - City or Town, Stete: Arlington, Virginia

21. Signeture of Funerel Service Licensee: [signature]

22. Name end Address of Fecility: Fleck Funeral Home, Inc. 7601 Sandy Spring Road, Laurel, Maryland 20707

Physician /Medical Examiner

23a. Part1. Enter the diseese, or complications that caused the deeth. Do not enter the mode of dying, such es cardiac or respiratory errest, shock, or heert feilure. List only one cause on eech line.

Approximate Interval Between Onset and Daeth

Immediate Ceuse (Final diseese or condition resulting in death)

e. Metastatic Ovarian Carcinoma — years

Due to (or as a consequence of):

Sequentially list conditions, if any, leeding to immediete cause. Enter Underlying Cause (Diseese or injury that initieted events resulting in deeth) Last

b.

Due to (or as a consequence of):

c.

Due to (or es e consequence of):

d.

Part II. **Other signifiicant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Intestinal obstruction, Post ileostomy

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Wes an eutopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Deeth (Check only one)

Hospitel: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA

Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Menner of Death: 1☒ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined

28a. Dete of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Piece of Injury - At home, ferm, street, fectory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

29e. Certifier (Check only one): 1☒ **Certifying Physician**: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner steted.

29b. Signeture and title of certifier: Rakesh arora

29c. License number: D20108

29d. Date signed (Month, Day, Year): 4/2/01

30. Neme end address of person who completed cause of death (Item 23a) (Type, Print): Rakesh Arora, MD 14300 Gallant Fox Lane, #222, Bowie, Maryland 20715

State Registrar

31. Dete filed (Month, Day, Year): APR 0 3 2001

32. Registrar's Signeture: Geneva G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit: Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 10087

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Samuel Leonard Grossfeld

2. Data of Death — Month: March Day: 29 Year: 2001

3. Time of Death: 2:59 PM

4a. Facility Name (If not institution, give street and number): Good Samaritan Hospital

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: N/A

Funeral Director

5. Social Security Number: 214-30-2823

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 69 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): March 6, 1932

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedant

10a. State: Maryland

10b. County: Baltimore

10c. City, Town or Location: Towson

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 1688 Yakona Road

10f. Zip Code: 21286

10g. Citizen of What Country?: United States

11. Meritel Stetus: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Wes Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No — If Yes, Give Yaar or Datas: Korean

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puarto Rican, atc.): 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Bleck, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 11 — College (1-4or 5+):

16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired): Plumber

16b. Kind of Business/Industry: Own Business

17. Father's Nama (First, Middle, Last): Michael Joseph Grossfeld

18. Mother's Neme (First, Middle, Maiden Surname): Lena Fischer

19a. Informent's Neme/Reletionship (Type, Print): Alice Louise Grossfeld/ Wife

19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code): 1688 Yakona Road Towson, MD 21286

20a. Method of Disposition: 1 [ ] Buriel 2 [X] Cremetion 3 [ ] Removal from Stete 4 [ ] Donetion 5 [ ] Other (Specify)

20b. Piece of Disposition (Neme of cemetery, cremetory or other piece): Chesapeake Crematory, Inc

Dete: 04/02/01

20c. Location - City or Town, State: Beltsville, MD

21. Signeture of Funeral Service Licensee: Laura C. Hardesty

22. Name and Address of Facility: CAFA Stephen D. Lohrmann P.A. 8717 Green Pastures Drive Baltimore, MD 21286

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications thet caused the death. Do not enter the mode of dying, such as cardiec or respiretory errest, shock, or heert feilure. List only one ceuse on eech line.

Approximate Interval Between Onset and Death

Immediate Ceusa (Finel disease or condition resulting in death): a. Lung Cancer — 6mos

Due te (or as a consequence of):

Sequentielly list conditions, if any, teading to immediete ceuse. Enter Underlying Cause (Disease or injury thet initieted events rasulting in death) Lest:

b. Due to (or es e consequence of):

c. Due to (or es e consequence of):

d.

Part ti. **Other significant conditions** contributing to death but not resulting in the underlying ceuse givan in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [X] Probably 4 [ ] Unknown

24a. Wes an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospitel: 1 [ ] Inpatient 2 [X] ER/Outpatient 3 [ ] DOA — Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Menner of Death: 1 [X] Naturel 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigetion 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how Injury occurred

28e. Piece of Injury - At home, ferm, street, fectory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, dete and piece, and due to the ceuse(s) end manner as stated. 2 [ ] **Medical Examiner:** On the basis of examinetion and/or investigation, in my opinion, deeth occurred et the time, date end piece, end due to the ceuse(s) end menner steted.

29b. Signature and title of certifier: Edward A Seidel

29c. License number: D38956

29d. Date signed (Month, Day, Year): April 1, 2001

30. Nama and address of person who completed ceuse of deeth (Item 23a) (Type, Print): Edward Seidel, 5601 Loch Raven Blvd, Baltimore MD 21239.

State Registrar

31. Date filed (Month, Day, Year): APR 0 3 2001

32. Registrar's Signetura: Brenda G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attanding Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

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4+1

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 10088

Physician / Medical Examiner

1. Decedent's Name (First, Middle, Last): Crystal Nadine Guessford
2. Date of Death: Month March Day 29 Year 01
3. Time of Death: 6:00 AM
4a. Facility Name (If not institution, give street and number): 9 Dartmouth Drive
4b. City, Town, or Location of Death: Hagerstown
4c. County of Death: Washington

Funeral Director

5. Social Security Number: 219-68-2222
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 44 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): JULY 16, 1956
9. Birthplace (State or Foreign Country): Pennsylvania

Usual Residence of Decedent

10a. State: Maryland
10b. County: Washington
10c. City, Town or Location: Hagerstown
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 9 Dartmouth Drive
10f. Zip Code: 21742
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 — College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Staff Accountant
16b. Kind of Business/Industry: Accounting Firm

17. Father's Name (First, Middle, Last): Eugene Flood
18. Mother's Name (First, Middle, Maiden Surname): Charlotte Myers

19a. Informant's Name/Relationship (Type, Print): Anthony L. Guessford/Husband
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 9 Dartmouth Drive Hagerstown, MD 21742

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Metro Crematory Inc.
Date: 3-30-01
20c. Location - City or Town, State: Baltimore, MD

21. Signature of Funeral Service Licensee: Edward A. Gregorchik
22. Name and Address of Facility: Cremation Society of MD, Inc. 299 Frederick Road Baltimore, MD 21228

Physician / Medical Examiner

23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): e. Cervical Cancer — 32 months

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Michael J. Mackowiak MD
29c. License number: 041667
29d. Date signed (Month, Day, Year): 3.29.01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Michael McCormack 11110 Medical Campus Suite 130 Hagerstown MD.

State Registrar

31. Date filed (Month, Day, Year): APR 03 2001
32. Registrar's Signature: Geneva G Sparks

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

DHMH 16 Rev 6/95

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 10089

Katherine Gerst 03-28-2001 455 pm
ManorCare-Rossville · 6600 Ridge Rd.
Baltimore, Maryland 21215-0020

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Katherine Delores Gerst
2. Date of Death (Month, Day, Year): March 28 2001
3. Time of Death: 4:55 pm
4a. Facility Name (If not institution, give street and number): Manor Care Nursing Home
4b. City, Town, or Location of Death: Rossville
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 213 28 6207
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 70 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): March 27 1931
9. Birthplace (State or Foreign Country): Baltimore, Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Baltimore
10c. City, Town or Location: Baltimore County
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 4310 Joppa Road
10f. Zip Code: 21236
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 8 | College (1-4or 5+): N/A
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Electrical Technician
16b. Kind of Business/Industry: E.O.G.

17. Father's Name (First, Middle, Last): Joseph Hallameyer
18. Mother's Name (First, Middle, Maiden Surname): Katherine Landerkin

19a. Informant's Name/Relationship (Type, Print): Lawrence G Gerst Sr (Husband)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4310 Joppa Road Baltimore, Maryland 21236

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Parkwood Cemetery | Date: March 31 2001
20c. Location - City or Town, State: Baltimore, Maryland

21. Signature of Funeral Service Licensee: Walter Joseph Chomacki
22. Name and Address of Facility: Lassahn Funeral Home Inc 7401 Belair Road Baltimore, Maryland 21236

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. End Stage Renal disease — 6 Months
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier
29c. License number: D45475
29d. Date signed (Month, Day, Year): 3/30/01

30. Name and Address of person who completed cause of death (Item 23a) (Type, Print): M. Kahnama 8100 Harford Rd. Balto. MD 21234

State Registrar

31. Date filed (Month, Day, Year): APR 03 2001
32. Registrar's Signature: Geneva G Sparks

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 10090

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Juanita May Gaylor

2. Date of Death: Month MARCH Day 30 Year 2001

3. Time of Death: 10:00 AM

4a. Facility Name (If not institution, give street and number): Howard County General Hospital

4b. City, Town, or Location of Death: Columbia

4c. County of Death: Howard

Funeral Director

5. Social Security Number: 577-42-9233

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 69 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): 02/19/1932

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: MD

10b. County: Howard

10c. City, Town or Location: Columbia

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 5131 Thunderhill Road

10f. Zip Code: 21045

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 12

College (1-4or 5+): 0

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker

16b. Kind of Business/Industry: Own home

17. Father's Name (First, Middle, Last): Roy Sell

18. Mother's Name (First, Middle, Maiden Surname): Grace Stein

19a. Informant's Name/Relationship (Type, Print): Robert Gaylor-husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 5131 Thunderhill Road, Columbia, MD., 21045

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Crestlawn Mem.Gardens

Date: 04/03/01

20c. Location - City or Town, State: Marriottsville, MD.

21. Signature of Funeral Service Licensee: Ronald Schroeder

22. Name and Address of Facility: Witzke Funeral Home Of Columbia, 5555 Twin Knolls Road, Columbia, MD., 21045

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. CORONARY ARTERY DISEASE — 1 YEAR

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

CHRONIC OBSTRUCTIVE PULMONARY DISEASE

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one)

Hospital: 1☐ Inpatient 2☒ ER/Outpatient 3☐ DOA

Other: 4☐ Nursing Home 5☐ Residence 8☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29e. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Scott Maurer, MD

29c. License number: D29909

29d. Date signed (Month, Day, Year): APRIL 2, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): SCOTT MAURER 2465 ROUTE 97 GLENWOOD MD 21738

State Registrar

31. Date filed (Month, Day, Year): APR 03 2001

32. Registrar's Signature: Geneva G Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

7

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

AMND ITM#19a PER F.H. G794 4-6-2001 JAB

Certificate of Death

Reg. No. 2001 | 0091

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Esthee Jeanne Gorman

2. Date of Death: Month MARCH Day 19 Year 2001

3. Time of Death: 3:30 AM

4a. Facility Name (If not institution, give street and number): 6079-1 Majors Lane

4b. City, Town, or Location of Death: Columbia

4c. County of Death: Howard

Funeral Director

5. Social Security Number: 192-18-1412

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 76 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): April 19, 1924

9. Birthplace (State or Foreign Country): Pennsylvania

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: MD

10b. County: Howard

10c. City, Town or Location: Columbia

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 6079-1 Majors Lane

10f. Zip Code: 21044

10g. Citizen of What Country? USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☒ Yes 2☐ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 12

College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): HOMEMAKER

16b. Kind of Business/Industry: OWN HOME

17. Father's Name (First, Middle, Last): James Crossland

18. Mother's Name (First, Middle, Maiden Surneme): Olive Crossland

19a. Informant's Name/Relationship (Type, Print): Kathleen WINGROVE Wingard- Daughter

19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code): 6079-1 Majors Lane, Columbia, Maryland 21044

20a. Mathod of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Piece of Disposition (Neme of cemetery, cramatory or other place): St. Mary's Cemetery

Date: 03/23/01

20c. Location - City or Town, State: Munhall, Penn.

21. Signature of Funeral Service Licensee: Bernard Witzke

22. Name and Address of Facility: Witzke Funeral Home of Columbia, 5555 Twin Knolls Road, Columbia, Maryland 21045

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications thet caused the death. Do not enter the mode of dying, such as cardiac or raspiratory errast, shock, or heart failure. List only one cause on each line.

Approximate Interval Batween Onset and Death

Immediete Cause (Final diseasa or condition resulting in death)

a. Emphysema. — 5 years

Dua to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initieted events resulting in death) Last

b.

Dua to (or as a consequenca of):

c.

Due to (or es e consequenca of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco uas contributs to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Wes en autopsy performed? 1☐ Yes 2☐ No

24b. Wara autopsy findings available prior to completion of cause of death? 1☐ Yas 2☐ No

25. Wes case referred to medical examiner? 1☐ Yes 2☐ No

26. Place of Daath (Check only ona)

Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA

Other: 4☐ Nursing Home 5☒ Residenca 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be datarmined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Placa of Injury - At home, farm, street, fectory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To tha best of my knowledga, daath occurred at tha tima, data and place, and due to tha causa(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the tima, data and place, and dua to tha cause(s) end menner steted.

29b. Signature and title of certifier: William Flowers MD

29c. Licanse number: P20789

29d. Date signed (Month, Day, Year): March 19, 2001.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): William Flowers MD 11055 Little Patuxent Pkwy Columbia MD

State Registrar

31. Date filed (Month, Day, Year): APR 03 2001

32. Registrar's Signature: Geneva G Sparks

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 10092

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: JOAN M. GIBSON

2. Date of Death Month / Day / Year: April 1, 2001

3. Time of Death: 8:50 AM

4a. Facility Name *(If not institution, give street and number)*: STELLA MARIS @ MERCY HOSPITAL

4b. City, Town, or Location of Death: BALTIMORE

4c. County of Death: N/A

Funeral Director

5. Social Security Number: 215-40-2527

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 66 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: 2-13-1935

9. Birthplace *(State or Foreign Country)*: WEST INDIES

Usual Residence of Decedent

10a. State: MD.

10b. County: N/A

10c. City, Town or Location: BALTIMORE

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 24 HALF PENNY LANE

10f. Zip Code: 21228

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* BLACK

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): -12- / College (1-4or 5+): -0-

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use ratired)*: BAR MAID

16b. Kind of Business/Industry: SERVICE

17. Father's Name *(First, Middle, Last)*: ALI HAZZIS

18. Mother's Name *(First, Middle, Maiden Surname)*: LUCRETIA SMITH

19a. Informant's Name/Relationship *(Type, Print)*: BELINDA LANE (DAUGHTER)

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 605 CROSBY RD. BALTIMORE, MARYLAND 21228

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: CEDAR HILL CEMETERY

Date: 4-5-2001

20c. Location - City or Town, State: GLEN BURNIE, MARYLAND

21. Signature of Funeral Service Licensee: Jonathan D. Hübner

22. Name and Address of Facility: PHILLIPS FUNERAL HOME, P.A. 1721-27 N. MONROE ST. BALTIMORE, MARYLAND 21217

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Esophageal Cancer

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☐ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☐ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☒ Other *(Specify)*: STELLA MARIS AT MERCY Hospice

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: MD

29c. License number: D40854

29d. Date signed *(Month, Day, Year)*: April 2, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): DAVID RISEBERG 301 St Paul Pl Baltimore, MD 21202

State Registrar

31. Date filed *(Month, Day, Year)*: APR 03 2001

32. Registrar's Signature: Donna G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

Medical Certification: To Be Completed by Physician/Medical Examiner

To the hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

AMND ITM#7&8 PER F.H. G794 4-3-2001 JAB

Reg. No. 2001 10093

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Eleanor L. Hildebrand

2. Date of Death: Month March Day 31 Year 2001

3. Time of Death: 12:35 AM

4a. Facility Name (If not institution, give street and number): Baltimore V.A. Medical Center

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: N/A

Funeral Director

5. Social Security Number: 168-40-2401

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): ~~57~~ 52 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): ~~10/01/1943~~ 9-1-1948

9. Birthplace (State or Foreign Country): PENNSYLVANIA

Usual Residence of Decedent

10a. State: PA. | 10b. County: MONACA | 10c. City, Town or Location: MONACA | 10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 909 MONACA RD. | 10f. Zip Code: 15061 | 10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☒ Yes 2☐ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): | College (1-4or 5+): 4YRS

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): REGISTERED NURSE

16b. Kind of Business/Industry: NURSE

17. Father's Name (First, Middle, Last): FLOYD A. KRUEST

18. Mother's Name (First, Middle, Maiden Surname): BETTY LASHBAUGH

19a. Informant's Name/Relationship (Type, Print): CHARLES E. HILDEBRAND(SON)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2530 LIBERTY PARKWAY BALTO.,MD. 21222.

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): OAK GROVE | Date: 04/04/2001

20c. Location - City or Town, State: FREEDOM, PA.

21. Signature of Funeral Service Licensee: William K. Lauer III

22. Name and Address of Facility: HENRY W. JENKINS & SONS CO. 6500 YORK RD. BALTO.,MD. 21212.

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. B-cell lymphoma	32 Days
Due to (or as a consequence of):		
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Cardio-pulmonary arrest	31 Days
Due to (or as a consequence of):		
	c.	
Due to (or as a consequence of):		
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year) | 28b. Time of Injury M | 28c. Injury at Work? 1☐ Yes 2☐ No | 28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: John Yang MD

29c. License number: P14715

29d. Date signed (Month, Day, Year): March 31, 2001

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): John Yang, MD BVAMC 10 N. Greene St. Baltimore, MD 21201

State Registrar

31. Date filed (Month, Day, Year): APR 03 2001

32. Registrar's Signature: Geneva G Sparks

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

1- For State Registrar

Reg. No. 2001 10094

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month / Day / Year	3. Time of Death
Doretha Holmes	March 31 2001	6:17 P M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
University of Maryland Medical Systems	Baltimore	N/A

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Yeer)	9. Birthplace (State or Foreign Country)
220-24-7641	1☐M 2☒F	75 Yrs.			APRIL 17 1925	MARYLAND

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MARYLAND	N/A	BALTIMORE	☒1 Yes 2☐ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
632 ARCHER STREET	21230	U.S.A.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced	1☐Yes 2☒No If Yes, Give Year or Dates:	1☐ Yes ☒ No Specify:	Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	18b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
5th grade		DOMESTIC	SELF-EMPLOYED

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
JAMES COATES	ANNIE COATES

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Joan Spencer/Daughter	6423 Oak Street, Glen Burnie, Maryland 21060

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, cremetory or other place)	Date	20c. Location - City or Town, State
1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	Cedar Hill Cemetery	04-05-01	GLEN BURNIE, MARYLAND

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
Charles W. Bowles	WILLIAM C BROWN COMMUNITY FUNERAL HOME PA 1206 W NORTH AVENUE

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Sepsis	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to (or as e consequence of):	
	b. Due to (or as a consequence of):	
	c. Due to (or as a consequence of):	
	d.	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month / Day / Year
1☐Yes 2☒No 9☐Unknown	1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) _____ 9☐Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Part I.

23e. Did tobacco use contribute to the cause of death?	24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐Yes 2☒No 3☐Probably 4☐Unknown	1☐Yes 2☒No	1☐Yes 2☐No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐Yes 2☒No	Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA	Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined		M	1☐Yes 2☐No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, snd due to the ceuse(s) end manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Yeer)
Charlotte Jones Boston MD	P13883	March 31, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Charlotte Boston MD 22 South Greene St., Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Dey, Year)	32. Registrar's Signature
APR 03 2001	Geneva G Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Medical Certification; To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

CPS
01-1726-005
BARRY HALL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar AMEND ITEM 23a,27,28a-f per ME G794 041301 SS

Certificate of Death

Reg. No. 2001 10095

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Data of Death Month	Day	Year	3. Time of Death
Barry R. Hall	March	28,	2001	12:35 PM

4a. Facility Name (If not institution, giva straat and number)	4b. City, Town, or Location of Death	4c. County of Death
Northwest Hospital Center	Randallstown	Baltimore

Funeral Director

5. Social Security Numbar	6. Sax	7. Aga (In yrs. last birthday)	If Under 1 Year: Months / Days	If Undar 24 Hrs.: Hours / Min.	8. Data of Birth (Month, Day, Yaar)	9. Birthplace (State or Foraign Country)
154-82-9832	1 [X] M 2 [ ] F	22 Yrs.			June 12, 1978	New Jersey

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
NJ	Cumberland	Vineland	1 [ ] Yes 2 [X] No

10e. Street and Number	10f. Zip Coda	10g. Citizen of What Country?
212 Red Crest Street	08361	USA

11. Marital Status	12. Was Dacedant Evar in U.S. Armed Forcas?	13. Was Decedant of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - Amarican Indian, Black, White, etc.
1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced	1 [ ] Yas 2 [X] No If Yas, Give Yaar or Datas:	1 [X] Yes 2 [ ] No Specify: Cuban/Puerto Rican	Specify: White

15. Decedent's Education (Specify only highast grade complatad)		16a. Decedent's Usual Occupation (Giva kind of work done during most of working lifa. DO NOT usa ratired)	16b. Kind of Businass/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12	0	Cook	Restaurant

17. Fathar's Nama (First, Middla, Last)	18. Mothar's Nama (First, Middle, Maidan Surname)
Ronald Hall	Natividad Lugo

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Addrass (Straat and Numbar or Rural Route Number, City or Town, Stata, Zip Coda)
Ronald Hall - Father	212 Red Crest Street, Vineland, New Jersey

20a. Mathod of Disposition	20b. Place of Disposition (Nama of cematary, cramatory or othar place)	Data	20c. Location - City or Town, Stata
1 [X] Burial 2 [ ] Cramation 3 [ ] Ramoval from Stata 4 [ ] Donation 5 [ ] Other (Specify)	Siloam Cemetery	4/2/01	Vineland, New Jersey

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
Mo1021	Hubbard Funeral Home, Inc. 4107 Wilkens Avenue Baltimore, Maryland 21229

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

23a. Part1. Entar tha disease, or complications that caused tha daath. Do not enter tha moda of dying, such as cardiac or respiratory arrest, shock, or haart failura. List only ona cause on aach line.

Approximate Intarval Batwaan Onsat and Death

Immediate Cause (Final disease or condition resulting in daath)
a. NARCOTIC INTOXICATION

Sequentially list conditions, if any, laading to immediata causa. Entar Underlying Cause (Disease or injury that initiated evants rasulting in daath) Last
b. Dua to (or as a consequence of):
c. Dua to (or as a consequenca of):
d. Dua to (or as a consequenca of):

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcoma of pragnancy	23d. Data of dalivary Month / Day / Year
1 [ ] Yas 2 [ ] No 9 [ ] Unknown	1 [ ] Liva birth 2 [ ] Fatal daath 3 [ ] Ectopic pregnancy 4 [ ] Pregnant at time of death 5 [ ] Other (specify) 9 [ ] Unknown	

Part II. **Other significant conditions** contributing to daath but not rasulting in tha undarlying causa givan in Part I.

23a. Did tobacco usa contribute to the causa of death?	24a. Was an autopsy performed?	24b. Wara autopsy findings available prior to completion of cause of death?
1 [ ] Yas 2 [ ] No 3 [ ] Probably 4 [ ] Unknown	1 [X] Yas 2 [ ] No	1 [X] Yes 2 [ ] No

25. Was case referred to medical examiner?	26. Placa of Daath (Check only ona) Hospital:	Other:
1 [X] Yas 2 [ ] No	1 [X] Inpatiant 2 [ ] ER/Outpatiant 3 [ ] DOA	4 [ ] Nursing Homa 5 [ ] Rasidence 6 [ ] Othar (Specify)

27. Mannar of Death	28a. Date of Injury (Month, Day Yaar)	28b. Tima of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1 [ ] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [X] Could not be datarmined	found: 3-27-01	unknown M	1 [ ] Yes 2 [X] No	unknown

28e. Placa of Injury - At homa, farm, straat, factory, offica building, etc. (Specify)	28f. Location (Straat and Numbar or Rural Route Number, City or Town, State)
home	9904 Marriottsville Rd., Randallstown, MD

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

29a. Cartifiar (Check only one) 1 [ ] **Certifying Physician:** To tha bast of my knowledga, death occurred at the time, data and placa, and dua to tha causa(s) and mannar as stated. 2 [X] **Medical Examiner:** On tha basis of axamination and/or invastigation, in my opinion, daath occurrad at tha tima, data and place, and due to tha causa(s) and mannar statad.

29b. Signature and title of certifiar	29c. Licensa number	29d. Data signad (Month, Day, Yaar)
	OCME	March 29, 2001

30. Name and address of person who completed cause of daath (Item 23a) (Type, Print)
J. Allen Locke, MD 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Data filad (Month, Day, Yaar)	32. Registar's Signatura
APR 03 2001	B. Sparks

DHMH 17 Rav 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 10096

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Betty Hackley

2. Date of Death: Month 03 Day 30 Year 01

3. Time of Death: 1AM

4a. Facility Name (If not institution, give street and number): Keswick multi care center

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: N/A

Funeral Director

5. Social Security Number: 219 22 1107

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 73 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): MAY 22, 1927

9. Birthplace (State or Foreign Country): MARYLAND

Usual Residence of Decedent

10a. State: MARYLAND

10b. County: N/A

10c. City, Town or Location: BALTIMORE

10d. Inside City Limits: ☒Yes 2☐ No

10e. Street and Number: 3345 KESWICK ROAD

10f. Zip Code: 21211

10g. Citizen of What Country? USA

11. Marital Status: 1☐ Never Married 2☐ Married ☒Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes ☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 9 College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): HOMEMAKER

16b. Kind of Business/Industry: IN OWN HOME

17. Father's Name (First, Middle, Last): HARRY M. MILLER

18. Mother's Name (First, Middle, Maiden Surname): MAMIE E. BEEKER

19a. Informant's Name/Relationship (Type, Print): ELAINE RICE DAUGHTER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3 TERESA MARIE CT. MILLERS, MD 21102

20a. Method of Disposition: ☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, cremetory or other place): LORRAINE PARK CEM.

Date: 4/2/01

20c. Location - City or Town, State: WOODLAWN, MD

21. Signature of Funeral Service Licensee: Tracy H Carpenter

22. Name and Address of Facility: BURGEE-HENSS-SEITZ FUNERAL HOME, INC. 3631 FALLS ROAD BALTIMORE, MD 21211

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Chronic Obstructive Pulmonary Disease — yrs

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☑ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☑ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: MD

29c. License number: D30433

29d. Date signed (Month, Day, Year): 3/30/01

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): M Kelly Gosnic 6001 N Charles St Baltimore MD 21204

State Registrar

31. Date filed (Month, Day, Year): APR 03 2001

32. Registrar's Signature: Bruce G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 10097

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Eugene Harrington
2. Date of Death Month: 03, Day: 22, Year: 2001
3. Time of Death: 9 03 AM
4a. Facility Name (If not institution, give street and number): University of Maryland
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 214-64-7906
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 46 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): June 22, 1954
9. Birthplace (State or Foreign Country): North Carolina

Usual Residence of Decedent

10a. State: Md.
10b. County: N/A
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 4505 Pimlico Rd.
10f. Zip Code: 21215
10g. Citizen of What Country? U.S.A.

11. Marital Status: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced
12. Wes Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12): 12th
College (1-4or 5+): N/A
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): CUSTODIAN
16b. Kind of Business/Industry: Colleges

17. Father's Name (First, Middle, Last): Gene Brown
18. Mother's Name (First, Middle, Maiden Surname): Patsy Harrington

19a. Informant's Name/Relationship (Type, Print): Patsy H. Jackson - mother
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4505 Pimlico Rd. Balto. md. 21215

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Mount Zion Cem
Date: 3/30/01
20c. Location - City or Town, State: Lansdowne, Md.

21. Signature of Funeral Service Licensee: Lewis T. Gwynn
22. Name and Address of Facility: Lewis T. Gwynn Funeral Home 4517 Park Heights Ave Balto. md. 21215

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death):
a. Sepsis
Due to (or as a consequence of):
b. liver failure
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1 [ ] Yes 2 [ ] No 9 [ ] Unknown
23c. If yes, outcome of pregnancy: 1 [ ] Live birth 2 [ ] Fetel death 3 [ ] Ectopic pregnency 4 [ ] Pregnant at time of death 5 [ ] Other (specify) 9 [ ] Unknown
23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown
24a. Was an autopsy performed? 1 [X] Yes 2 [ ] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Wes case referred to medical examiner? 1 [X] Yes 2 [ ] No
26. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 8 [ ] Other (Specify)
27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification; To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: [illegible], MD
29c. License number: 13037
29d. Date signed (Month, Day, Year): 03/22/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Amanda Rosenberg, MD 22 S. Greene St Baltimore, MD 21201

State Registrar

31. Date filed (Month, Day, Year): APR - 3 2001
32. Registrar's Signature: [illegible]

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 10098

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): LOIS M. HOWE

2. Date of Death: Month MARCH Dey 23, Year 2001

3. Time of Death: 12:30am

4e Facility Name (If not institution, give street and number): 303 SOUTH CORNWALL STREET

4b. City, Town, or Location of Death: BALTIMORE

4c. County of Death: N/A

Funeral Director

5. Social Security Number: 214-30-2546A

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 83 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): DEC 19, 1917

9. Birthplace (State or Foreign Country): PENNSYLVANIA

Usual Residence of Decedent

10a. Stete: MD

10b. County: N/A

10c. City, Town or Location: BALTIMORE CITY

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 303 SOUTH CORNWALL STREET

10f. Zip Code: 21224

10g. Citizen of What Country?: U.S.A.

11. Maritel Stetus: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No Specify:

14. Raca - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elemantary/Secondary (0-12): 12 | College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): REMITTANCE

16b. Kind of Business/Industry: AT&T

17. Father's Name (First, Middle, Last): HAROLD HARM

18. Mother's Name (First, Middle, Maiden Surname): LEONA RICHY

19e. Informent's Name/Relationship (Type, Print): DOLORES ANN BOCIANOWSKI-DAUGHTER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 8159 PARK HAVEN ROAD BALTIMORE, MD 21222

20a. Method of Disposition: 1☐ Burial 2☒ Cremetion 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): BALTIMORE-WASHINGTON CREMATORY

Date: 3/27/01

20c. Location - City or Town, State: LAUREL, MARYLAND

21. Signature of Funeral Service Licensee: Elizabeth Selinski

22. Neme and Address of Fecility: CHARLES S. ZEILER & SON, INC. 6224 EASTERN AVENUE BALTIMORE, MD 21224

Physician /Medical Examiner

23a. Part1. Enter the disease, or complicetions thet caused the death. Do not enter the mode of dying, such as cardiac or respiratory errast, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset end Death

Immediate Cause (Final disease or condition resulting in death)
a. Breast Cancer — 1998

Due to (or as a consequence of):
b. Diabetis Mellitus — 1998.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated evants resulting in death) Last
c. Hypertension

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: MD

29c. License number: D44793

29d. Date signed (Month, Day, Year): 3/24/01

30. Neme and address of person who completed cause of death (Item 23a) (Type, Print): DR. SINAI 6730 HOLABIRD AVE BALTIMORE, MD 21222

State Registrar

31. Date filed (Month, Day, Year): APR 0 3 2001

32. Registrar's Signature: Geneva G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 10099

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): DAVID ANDREW HYER, JR

2. Date of Death: Month 3 Day 28 Year 01

3. Time of Death: 21:07

4a. Facility Name (If not institution, give street and number): HOWARD COUNTY GENERAL HOSPITAL

4b. City, Town, or Location of Death: COLUMBIA

4c. County of Death: HOWARD

Funeral Director

5. Social Security Number: 215-38-9101

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 63 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): 05-28-37

9. Birthplace (State or Foreign Country): NEW JERSEY

Usual Residence of Decedent

10a. State: MD

10b. County: HOWARD

10c. City, Town or Location: COLUMBIA

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 6453 RED KEEL

10f. Zip Code: 21044

10g. Citizen of What Country? USA

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [ ] Widowed 4 [X] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No. If Yes, Give Year or Dates: 1955 1956 1961-1963

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementery/Secondary (0-12): 12; College (1-4or 5+): 3

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Security Agent

16b. Kind of Business/Industry: NSA- Government

17. Father's Name (First, Middle, Last): David Hyer, Sr.

18. Mother's Name (First, Middle, Maiden Surname): Norma Jorgenson

19a. Informant's Name/Relationship (Type, Print): Phyllis Rice- Companion

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 6453 Red Keel, Columbia, Maryland 21044

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from Stete 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Baltimore WashingtonCrem

Date: 04/02/2001

20c. Location - City or Town, State: Laurel, Maryland

21. Signature of Funeral Service Licensee: ▶ Heather A. Brown

22. Name and Address of Facility: Witzke Funeral Home, Inc. 5555 Twin Knolls Road, Columbia, Maryland 21045

Physician /Medical Examiner

23a. Part I. Enter the diseese, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximete Interval Between Onset and Death

Immediate Cause (Final diseese or condition resulting in death): a. acute myocardial infarction — 30 minutes

Due to (or es e consequence of):

Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:

b.

Due to (or as a consequenca of):

c.

Due to (or es e consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [X] ER/Outpatient 3 [ ] DOA; Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Netural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigetion 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1 [X] Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] Medical Examiner: On the besis of examinetion end/or investigation, in my opinion, death occurred et the time, date end place, and due to the cause(s) and manner stated.

29b. Signature end title of certifier: ▶ Dag Mills MD

29c. License number: D26621

29d. Date signed (Month, Day, Year): March 28, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): 3460 Ellicott Center Drive, Ellicott City, MD 21043

State Registrar

31. Date filed (Month, Day, Year): APR 03 2001

32. Registrer's Signature: ▶ Geneva G Sparks

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use es the burial-transit

10

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 10100

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
Lester Leander Jackson	March 30, 2001	9:25 AM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Stella Maris Hospice	Timonium	Baltimore

Funeral Director

5. Social Security Number	8. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
218-09-1487	1 [X] M 2 [ ] F	80 Yrs.			July 8, 1920	Maryland

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Baltimore	Towson	1 [ ] Yes 2 [X] No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
1006 Cowpens Avenue	21286	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced	1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:	1 [ ] Yes 2 [X] No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	18b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
	4	Engineer	Martin Marietta

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Lester L. Jackson	Nannie Brashears

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Aleda S. Jackson / wife	1006 Cowpens Avenue Towson, MD 21286

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	Metro Crematory, Inc.	4/1/01	Baltimore, MD

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
George E. MacNabb	Cremation Society of Maryland, Inc. 299 Frederick Road Baltimore, MD 21228

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Hepatic Failure	1 month
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of): b. Chronic active hepatitis B	5 years
	Due to (or as a consequence of): c.	
	Due to (or as a consequence of): d.	

IF FEMALE: 23b. Was decedent pregnent in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month Day Year
1 [ ] Yes 2 [ ] No 9 [ ] Unknown	1 [ ] Live birth 2 [ ] Fetal death 3 [ ] Ectopic pregnancy 4 [ ] Pregnent at time of death 5 [ ] Other (specify) _____ 9 [ ] Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Prostate cancer

23e. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1 [ ] Yes 2 [X] No	1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1 [ ] Yes 2 [X] No	Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA	Other: 4 [ ] Nursing Home 5 [ ] Residence 8 [X] Other (Specify) Hospice

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined		M	1 [ ] Yes 2 [ ] No	
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
MD	D20688	March 30, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Carl S. Friedman, M.D. 515 Fairmount Avenue Towson, MD 21286

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
APR 03 2001	G Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Item 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification; To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 10101

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)			2. Date of Death (Month, Day, Year)	3. Time of Death
VIRGINIA	KATHRYN	JENKINS	March 29 2001	11:00 P M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
NORTH ARUNDEL HOSPITAL ASSOCIATION	GLEN BURNIE	ANNE ARUNDEL

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
217-14-7424	1☐M 2☒F	81 Yrs.			FEB. 19, 1920	WV

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MARYLAND	ANNE ARUNDEL	GLEN BURNIE	1☐Yes 2☒No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
640 HALLMARK DRIVE	21061	U.S.A.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐Never Married 2☐Married 3☒Widowed 4☐Divorced	1☐Yes 2☒No If Yes, Give Year or Dates:	1☐Yes 2☒No Specify:	Specify WHITE

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use ratired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12		BOOKKEEPER	RETAIL

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
CHARLES E. OATS	KATHRYN VERNON

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
DOUGLAS A. JENKINS (SON)	640 HALLMARK DRIVE, GLEN BURNIE, MD. 21061

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	GLEN HAVEN MEMORIAL PARK	4/2/2001	GLEN BURNIE, MD.

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶	SINGLETON FUNERAL HOME, P.A., 1 SECOND AVENUE, S.W., GLEN BURNIE, MD. 21061

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Myocardial Infarction	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of):	
	c. Due to (or as a consequence of):	
	d. Due to (or as a consequence of):	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery
1☐Yes 2☐No 9☐Unknown	1☐Liva birth 2☐Fetal daath 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown	Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☑Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐Yes 2☑No	1☐Yes 2☑No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐Yes 2☑No	Hospital: 1☑Inpatient 2☐ER/Outpatient 3☐DOA	Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death	28a. Data of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☑Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined		M	1☐Yes 2☐No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one)
1☑**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ George E. Wicks III M.D.	D41365	March 29, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
George E. Wicks III M.D. 301 Hospital Drive, Glen Burnie, MD. 21061

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
APR 03 2001	▶ Geneva G Sparks

DHMH 17 Rev 1/2001

ORIGINAL

To be Completed by Funeral Director

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 28a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Jenkins, Virginia K.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 10102

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): JANET L. JENKINS
2. Date of Death: Month MAR Day 30 Year 2001
3. Time of Death: 4:00 pm
4a. Facility Name (If not institution, give street and number): HOWARD COUNTY GENERAL HOSPITAL
4b. City, Town, or Location of Death: COLUMBIA
4c. County of Death: HOWARD

Funeral Director

5. Social Security Number: 212-98-2921
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 35 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 08/07/1965
9. Birthplace (State or Foreign Country): Florida

Usual Residence of Decedent

10a. State: MD
10b. County: Prince George's
10c. City, Town or Location: Laurel
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 14912 Cherry Wood Drive
10f. Zip Code: 20707
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, give Yeer or Detes:
13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indien, Bleck, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondery (0-12): 12 | College (1-4or 5+): 0
16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired): Medical Collections
16b. Kind of Business/Industry: MedStar

17. Father's Neme (First, Middle, Last): Alma Leon Jenkins
18. Mother's Neme (First, Middle, Maiden Surneme): Bobbie Louise Sheffield

19a. Informent's Name/Relationship (Type, Pnnt): Sarah Diane Wilcox-sister
19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 14912 Cherry Wood Drive, Laurel, Maryland, 20707

20e. Method of Disposition: 1☐ Burial 2☒ Cremetion 3☐ Removel from Stete 4☐ Donation 5☐ Other (Specify)
20b. Piece of Disposition (Name of cemetery, cremetory or other place): Balt./Wash. Crematory
Date: 04/03/01
20c. Location - City or Town, Stete: Laurel, Maryland

21. Signature of Funeral Service Licensee: ▶ Heather A. Brown
22. Neme end Address of Fecility: Fleck Funeral Home 7601 Sandy Spring Road, Laurel, Maryland, 20707

Physician /Medical Examiner

23a. Pert1. Enter the diseese, or complications that caused the deeth. Do not enter the mode of dying, such es cerdiac or respiratory errest, shock, or heart failure. List only one cause on eech line.

Approximate Interevl Between Onset and Death

Immediate Cause (Final diseese or condition resulting in deeth)
a. CARDIOMYOPATHY — YEARS

Due to (or as e consequence of):
b. HYPERTENSION — YEARS

Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury thet initieted events resulting in deeth) Last
Due to (or es e consequence of):
c. MORBID OBESITY — YEARS

Due to (or as a consequence of):
d.

Pert II. **Other slgnificant conditfons** contributing to death but not resulting in the underlying ceuse given in Part I.: RENAL INSUFFICIENCY

23b. Did tobacco use contributa to the ceuse of death? 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

24e. Was an autopsy performed? 1☐ Yes 2☑ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No
26. Place of Death (Check only one): Hospitel: 1☑ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Deeth: 1☑ Netural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Piece of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rurel Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, date and piece, end due to the ceuse(s) and manner as stated. 2☐ **Medicef Examiner:** On the basis of examinetion end/or investigation, in my opinion, death occurred et the time, dete and piece, and due to the ceuse(s) and manner stated.

29b. Signature and title of certifier: ▶ Bhandiani MD
29c. License number: D42892
29d. Date signed (Month, Day, Year): MAR 30 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): FRANCIS CHADIAN 10724 LITTLE PATUXENT PKWY COLUMBIA MD 21044

State Registrar

31. Dete filed (Month, Day, Year): APR 0 3 2001
32. Registrar's Signeture: ▶ Jennie G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than 'natural', or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 10103

21-44-4493

Physician / Medical Examiner

1. Decedent's Name (First, Middle, Last): ROBERT G. JACKSON
2. Date of Death: Month 04 Day 01 Year 2001
3. Time of Death: 1:43 AM
4a. Facility Name (If not institution, give street and number): BALTIMORE VETERANS HOSPITAL
4b. City, Town, or Location of Death: BALTIMORE
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 212-44-4493
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 55 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): JULY 26, 1945
9. Birthplace (State or Foreign Country): MARYLAND

Usual Residence of Decedent

10a. State: Md.
10b. County: N/A
10c. City, Town or Location: BALTIMORE
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 2405 E. OLIVER STREET
10f. Zip Code: 21213
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [ ] Widowed 4 [X] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No — If Yes, Give Year or Dates: 2-12-64 to 1-26-67
13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: BLACK

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12TH | College (1-4 or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): CUSTODIAN
16b. Kind of Business/Industry: BALTIMORE CITY DEPT. OF EDUCATION

17. Father's Name (First, Middle, Last): LESTER JACKSON
18. Mother's Name (First, Middle, Maiden Surname): CORA MOORE

19a. Informant's Name/Relationship (Type, Print): WILLIAM JACKSON (BROTHER)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 5701 THE ALAMEDA BALTIMORE, MD. 21218

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): GARRISON FOREST VETERANS CEM. OWINGSMILLS, MD. — Date: APR. 5, 2001
20c. Location - City or Town, State:

21. Signature of Funeral Service Licensee: Bernadine V. Scruggs
22. Name and Address of Facility: CALVIN B. SCRUGGS FUNERAL HOME, 1412 E. PRESTON ST. BALTO, MD. 21213

Physician / Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	e. ATRIAL FIBRILLATION	10 DAYS
Due to (or as a consequence of):	b. ADENOCARCINOMA OF LUNG	17 DAYS
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of): c.	
	Due to (or as a consequence of): d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: PLEURO PERICARDIAL EFFUSION

23b. Did tobacco use contribute to the cause of death? 1 [X] Yes 2 [ ] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year):
28b. Time of Injury: M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred:
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify):
28f. Location (Street and Number or Rural Route Number, City or Town, State):

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Daniel J. Franco M.D.
29c. License number: P12699
29d. Date signed (Month, Day, Year): 04/01/01

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): DANIEL J. FRANCO M.D. BALTIMORE VAMC 10 N. GREENE ST BALT, MD 21201

State Registrar

31. Date filed (Month, Day, Year): APR 03 2001
32. Registrar's Signature: Lenore D. Sparks

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 10104

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): CHARLES E. KENT JR

2. Deta of Deeth: Month March Day 24 Year 2001

3. Time of Death: 13:34

4e Facility Name (If not institution, give street and number): Sinai Hospital of Baltimore

4b. City, Town, or Location of Death: Baltimore City

4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 219-40-4038

6. Sex: 1☒M 2☐F

7. Age (In yrs. last birthdey): 56 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): 2-16-1945

9. Birthplace (State or Foreign Country): Maryland

Usuel Residence of Decedent

10a. Stete: MD

10b. County:

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1☒Yes 2☐No

10e. Street and Number: 3917 Belle Ave.

10f. Zip Code: 21215

10g. Citizen of What Country? USA

11. Merital Stetus: 1☐Never Married 2☒Married 3☐Widowed 4☐Divorced

12. Was Decedent Evar in U.S. Armed Forces? 1☐Yes 2☒No If Yes, Give Yeer or Detes:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No Specify:

14. Race - American Indian, Bleck, White, etc. Specify: BLACK

15. Decedent's Education (Specify only highest grada completed): Elementery/Secondery (0-12): 12 / College (1-4or 5+):

16a. Decedent's Usuel Occupation (Give kind of work done duning most of working life. DO NOT use retired): Juvenile Counselor

16b. Kind of Business/Industry: Juvenile Justice

17. Fether's Neme (First, Middle, Lest): Charles E. Kent Sr.

18. Mother's Neme (First, Middle, Maiden Sumame): Mary Lee Duncan

19a. Informent's Neme/Reletionship (Type, Pnint): Mabel Kent/Wife

19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code): 4505 Mannasota Ave. Baltimore, MD 21206

20a. Method of Disposition: 1☐Burial 2☒Cremetion 3☐Remove from State 4☐Donation 5☐Other (Specify)

20b. Piece of Disposition (Neme of cemetery, cremetory or other place): Metro Crematory

Dete: 3-29-01

20c. Location - City or Town, Stata: Baltimore, Md

21. Signature of Funeral Service Licensee: ▶ Wm C Brown

22. Nama and Address of Facility: William C. Brown Community Funeral Home P.A. 1206 W. North Ave.

Physician /Medical Examiner

23a. Part1. Enter the disease, or complicetions thet caused the deeth. Do not enter the moda of dying, such es cardiac or respiretory arrest, shock, or heart failure. List only one cause on eech line.

Approximete Interval Between Onset end Deeth

Immediete Cause (Final disease or condition resulting in deeth)

a. Arrhythmia — 1 hour

Due to (or es a consequence of):

b. Blood loss — 6 hours

Sequentielly list conditions, if any, leading to immediete cause. Enter Underlying Ceuse (Diseese or injury thet initieted events resulting in death) Last

Due to (or es a consequence of):

c. Cellulitis status Post Debridement — 24 hours

Due to (or as e consequence of):

d. Congestive heart failure Ejection fraction 10%

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Diabetes

23b. Did tobacco use contribute to the cause of death? 1☑Yes 2☐No 3☐Probably 4☐Unknown

24a. Wes an autopsy performed? 1☐Yes 2☐No

24b. Were autopsy findings aveilable prior to completion of cause of death? 1☐Yes 2☑No

25. Was case referred to medical examiner? 1☐Yes 2☑No

26. Place of Death (Check only one): Hospital: 1☑Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☐Residence 8☐Other (Specify)

27. Manner of Death: 1☑Neturel 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigetion 6☐Could not be determined

28a. Dete of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury et Work? 1☐Yes 2☐No

28d. Describe how injury occurred

28e. Piece of Injury - At home, farm, street, fectory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑**Certifying Physician:** To the best of my knowledge, deeth occurred at the time, dete end place, end due to the cause(s) and menner as stated. 2☐**Medical Examiner:** On the basis of examination end/or investigetion, in my opinion, deeth occurred at the time, date end place, and dua to the cause(s) and menner steted.

29b. Signature and title of certifier: ▶ Ledys Julia Valle M.D.

29c. Licansa number: RES-000

29d. Dete signed (Month, Day, Year): March 24, 2001

30. Neme and address of person who completed cause of death (Item 23a) (Type, Print): Ledys Valle MD Sinai Hospital of Maryland 2401 W. Belvedere Ave Baltimore Maryland

State Registrar

31. Date filed (Month, Day, Year): APR 0 3 2001

32. Registrer's Signeture: ▶ Geneva G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To be completed by Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

To Be Completed by Funeral Director

Kent Jr, Charles E.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 10105

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Mildred A. Karl

2. Date of Death (Month, Day, Year): March 29 2001

3. Time of Death: 9:40 pm

4a. Facility Name (If not institution, give street and number): Stella Maris

4b. City, Town, or Location of Death: Timonium

4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 218-52-4864

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 97 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): 10/8/1903

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: MD

10b. County: N/A

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 2923 Clearview Avenue

10f. Zip Code: 21234

10g. Citizen of What Country? U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4 or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker

16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): Joseph Gough

18. Mother's Name (First, Middle, Maiden Surname): Unknown Anna Hoeck

19a. Informant's Name/Relationship (Type, Print): Anita D'Amico/Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2923 Clearview Avenue Baltimore, Maryland 21234

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Holy Redeemer Cemetery

Date: 4/2/01

20c. Location - City or Town, State: Baltimore, Maryland

21. Signature of Funeral Service Licensee: [signature]

22. Name and Address of Facility: John C. Miller Inc. 6415 Belair Road Baltimore, Maryland 21206

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Recurrent strokes

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Cerebrovascular thrombosis

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Ischemic heart disease

Chronic lung disease

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature] MD

29c. License number: D 15504

29d. Date signed (Month, Day, Year): 3-30-01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Eddie Nakhuda, M.D. 2300 Dulaney Valley Rd Timonium, Md 21093

State Registrar

31. Date filed (Month, Day, Year): APR 03 2001

32. Registrar's Signature: Geneva G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

NAME: KARL, MILDRED

4

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 10106

Physician /Medical Examiner

1. Decedent's Neme (First, Middle, Last): RUTH KIDNER
2. Dete of Deeth — Month, Dey, Year: March 30, 2001
3. Time of Death: 7:50pm
4a. Fecility Neme (If not institution, give street and number): Maryland Masonic Home
4b. City, Town, or Location of Deeth: Cockeysville
4c. County of Deeth: Baltimore

Funeral Director

5. Socisl Security Number: 217-18-1904
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthdey): 89 Yrs. — If Under 1 Yeer: Months / Deys — If Under 24 Hrs.: Hours / Min.
8. Dete of Birth (Month, Dey, Yeer): Aug 17, 1911
9. Birthplece (Stete or Foreign Country): Maryland

Usuel Residence of Decedent

10e. Stete: Maryland
10b. County: Baltimore
10c. City, Town or Location: Cockeysville
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 300 International Circle
10f. Zip Code: 21030
10g. Citizen of Whet Country?: USA

11. Meritel Stetus: 1☐ Never Merried 2☐ Merried 3☒ Widowed 4☐ Divorced
12. Wes Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yeer or Detes:
13. Wes Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexicen, Puerto Ricen, etc.) 1☐ Yes 2☒ No Specify:
14. Rece - Americen Indien, Bleck, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementery/Secondary (0-12): 10 — College (1-4or 5+): n/a
16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired): Homemaker
16b. Kind of Business/Industry: Own Home

17. Father's Neme (First, Middle, Last): Leon P. Frank
18. Mother's Neme (First, Middle, Meiden Surneme): Anna K. Plumer

19e. Informent's Neme/Reietionship (Type, Print): Carol R. Sorrell/Daughter
19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code): 1003 Donington Circle, Towson, MD 21204

20e. Method of Disposition: 1☒ Burial 2☐ Cremetion 3☐ Removel from Stete 4☐ Donetion 5☐ Other (Specify)
20b. Pleca of Disposition (Neme of cemetery, crematory or other piece): Parkwood Cemetery
Dete: 4/2/01
20c. Location - City or Town, Stete: Parkville, Maryland

21. Signature of Funerel Service Licensee: Michael J. Flagle
22. Neme end Address of Facility: Lemmon Funeral Home, 10 W. Padonia road, Timonium, MD 21093

Physician /Medical Examiner

23e. Pert I. Enter the disease, or complicetions thet cesed the deeth. Do not enter the mode of dying, such es cardiec or respiretory arrest, shock, or heert feilure. List only one ceuse on eech line. — Approximete Interve! Between Onset end Deeth

Immediete Cause (Finel diseese or condition resulting in deeth): e. Congestive Heart Failure
Due to (or es e consequence of):
Sequentielly list conditions, if eny, leeding to immediete cause. Enter Underlying Cause (Diseese or injury thet initieted events resulting in deeth) Last:
b. Cardiomyopathy
Due to (or es e consequence of):
c.
Due to (or es e consequence of):
d.

Pert II. **Other significent conditions** contributing to death but not resulting in the underlying cause given in Part I.: Diabetes, Rheumatic Fever, Dementia

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Wes en autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings eveileble prior to completion of cause of death? 1☐ Yes 2☒ No

25. Wes case referred to medicel exeminer? 1☐ Yes 2☒ No
26. Plece of Deeth (Check only one): Hospitel: 1☐ Inpetient 2☐ ER/Outpetient 3☐ DOA — Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Menner of Deeth: 1☒ Netural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined
28e. Dete of Injury (Month, Dey Yeer):
28b. Time of injury: M
28c. Injury et Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred:
28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify):
28f. Locetion (Street and Number or Rural Route Number, City or Town, State):

29e. Certifier (Check only one): ☒ 1 **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the cause(s) end manner es steted. ☐ 2 **Medical Examiner:** On the basis of exemination end/or investigetion, in my opinion, deeth occurred et the time, date end pieca, and due to the cause(s) and menner steted.

29b. Signeture end title of certifier: R. Liberto, MD.
29c. License number: D21464
29d. Dete signed (Month, Dey, Yeer): 4/1/01

30. Neme end address of person who completed cause of deeth (Item 23a) (Type, Print): ROBERT LIBERTO MD. 3508 BANK ST 21224

State Registrar

31. Dete filed (Month, Dey, Yeer): APR 03 2001
32. Registrer's Signeture: Jeanne G Sparks

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 10107

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Grace, Kugel
2. Date of Death: Month April Day 1 Year 2001
3. Time of Death: 2345
4a. Facility Name (If not Institution, give street and number): Good Samaritan Hospital
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 213-20-2545
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 93 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): July 29, 1907
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: MD
10b. County: N/A
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 6116 Belair Road
10f. Zip Code: 21206
10g. Citizen of Whet Country?: U.S.A.

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yeer or Detes:
13. Wes Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No Specify:
14. Rece - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Accountant
16b. Kind of Business/Industry: Dairy

17. Father's Neme (First, Middle, Last): John F. Kugel
18. Mother's Name (First, Middle, Maiden Surneme): Hattie Virginia Cox

19a. Informent's Name/Relationship (Type, Print): Alice V. Euler- Niece
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 5214 Biddison Lane Baltimore, Maryland 21206

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Neme of cemetery, crematory or other piece): Parkwood Cemetery
Date: 4/5/01
20c. Location - City or Town, State: Baltimore, Maryland

21. Signature of Funeral Service Licensee: ▶ Heather Cain
22. Name and Address of Facility: Leonard J.Ruck, Inc. 5305 Harford Road Baltimore, Maryland 21214

Physician /Medical Examiner

23a. Part1. Enter the disease, or complicetions that caused the deeth. Do not enter the mode of dying, such es cardiec or respiratory errest, shock, or heart failure. List only one cause on each line.

Approximete Interval Between Onset snd Death

Immediate Ceuse (Final disease or condition resulting in death)
a. Sepsis — hours.
Due to (or es e consequence ot):
b. Urinary tract Infection. — days.
Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Last
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
dementia.
Coronary Artery Disease.
Common bile duct Obstruction.

23b. Did tobacco uss contributs to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Wes en autopsy performed? 1☐ Yes 2☒ No
24b. Were eutopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Wes case referred to medical exeminer? 1☐ Yes 2☒ No
26. Place of Death (Check only one) Hospitel: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Menner of Death: 1☒ Naturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Piece of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street snd Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1☒ **Certifying Physician**: To the best of my knowledge, death occurred et the time, dete end piece, end due to the ceuse(s) and manner es stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigetion, in my opinion, deeth occurred at the time, date and piece, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Luberm.D
29c. License number: #D0055998
29d. Dete signed (Month, Day, Year): April 2 2001

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): Pearl Luber m.D / Good Samaritan Hospital 5601 Loch Raven Boulevard Baltimore MD 21239-2995

State Registrar

31. Date filed (Month, Day, Year): APR 03 2001
32. Registrar's Signeture: ▶ [signature]

ORIGINAL

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use es the burial-transit

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 10108

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Muriel Elizabeth Lee

2. Date of Death (Month, Day, Year): March 29, 2001

3. Time of Death: 12:30 A.M.

4a. Facility Name (If not institution, give street and number): Genesis Eldercare

4b. City, Town, or Location of Death: Glen Burnie

4c. County of Death: Anne Arundel

Funeral Director

5. Social Security Number: 218-44-1693

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 53 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): May 17, 1947

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Anne Arundel

10c. City, Town or Location: Glen Burnie

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 6662 Roberts Court #C-88

10f. Zip Code: 21061

10g. Citizen of What Country?: USA

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 8th grade

College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker

16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): Robert R. Lee

18. Mother's Name (First, Middle, Maiden Surname): Leonia I. Brown

19a. Informant's Name/Relationship (Type, Print): Brontus Lee/ Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2641 Marbourne Avenue Baltimore, Maryland 21230

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Voshell Memorial Gardens

Date: 4/2/01

20c. Location - City or Town, State: Dundalk, Maryland

21. Signature of Funeral Service Licensee: Jerry Harris

22. Name and Address of Facility: Chatman-Harris Funeral Home 5240 Reisterstown Road Baltimore, Maryland 21215

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Metastatic Hepatocellular Carcinoma

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Cirrhosis of liver

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one)

Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA

Other: 4☒ Nursing Home 5☐ Residence 8☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

29a. Certifier (Check only one): 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Jorge Vallecillo MD

29c. License number: D26203

29d. Date signed (Month, Day, Year): 3/30/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Jorge Vallecillo MD 1319 Light St. Baltimore MD 21230

State Registrar

31. Date filed (Month, Day, Year): APR 03 2001

32. Registrar's Signature: Rebecca G Sparks

DHMH 16 Rev 6/95

2001 APR -2 PM 2:37

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 10109

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Thomas D Lloyd
2. Date of Death: Month March Day 31 Year 2001
3. Time of Death: 0600
4a. Facility Name (If not institution, give street and number): Good Samaritan Hospital
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 278-10-7512
6. Sex: 1 ☒ M 2 ☐ F
7. Age (In yrs. last birthday): 89 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): NOV 23, 1911
9. Birthplace (State or Foreign Country): NY

Usual Residence of Decedent

10a. State: MD
10b. County: BALTIMORE
10c. City, Town or Location: PARKVILLE
10d. Inside City Limits: 1 ☐ Yes 2 ☒ No
10e. Street and Number: 3209 TAYLOR AVE
10f. Zip Code: 21234
10g. Citizen of What Country? U.S.A

11. Marital Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☒ Yes 2 ☐ No If Yes, Give Year or Dates: WWII
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)
Elementery/Secondery (0-12): 12th
College (1-4or 5+): 3 1/2 YRS
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): LT. COL.
16b. Kind of Business/Industry: U.S. MILITARY

17. Father's Name (First, Middle, Last): THOMAS LLOYD
18. Mother's Name (First, Middle, Maiden Surname): MARGARET O'BRIEN

19a. Informant's Name/Relationship (Type, Print): GERTRUDE LLOYD (WIFE)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3209 TAYLOR AVE, Balto. MD 21234

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, cremetory or other place): PARKWOOD CEMETERY
Date: 4/3/01
20c. Location - City or Town, State: PARKVILLE, MD

21. Signature of Funeral Service Licensee: Paul M. Stella
22. Name and Address of Facility: HARTLEY MILLER FUNERAL HOME CHTD, 7527 HARFORD RD. BALTO MD 21234

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Pneumonia — one week

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No
26. Place of Death (Check only one): Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: Wendy L. Wright MD
29c. License number: D0056247
29d. Date signed (Month, Day, Year): March 31 2001
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Wendy L. Wright, MD 5601 Loch Raven Blvd, Baltimore MD 21239

State Registrar

31. Date filed (Month, Day, Year): APR 03 2001
32. Registrar's Signature: Sandra D. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

1- For State Registrar

Reg. No: 2001 10110

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)			2. Date of Death Month Day Year	3. Time of Death
DAVID	HAMIL	LATHE	MARCH 15, 2001	12:30 AM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
NORTH ARUNDEL HOSPITAL ASSOCIATION	GLEN BURNIE	ANNE ARUNDEL

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
215-22-2657	1 [X] M 2 [ ] F	76 Yrs.			MARCH 13, 1925	MARYLAND

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MARYLAND	ANNE ARUNDEL	MILLERSVILLE	1 [ ] Yes 2 [X] No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
8250 ELVATON ROAD	21108	U.S.A.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced	1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: 1940-1942	1 [ ] Yes 2 [X] No Specify:	Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	18b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
10		FOREMAN	MACHINST

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
HARRY LATHE	MARY SORG

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
LINDA FUNKHOUSER (DAUGHTER)	8250 ELVATON ROAD, MILLERSVILLE, MD. 21108

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	GLEN HAVEN MEMORIAL PARK	3/19/2001	GLEN BURNIE, MD.

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ MD Lic M0122d	SINGLETON FUNERAL HOME, P.A., 1 SECOND AVENUE, S.W., GLEN BURNIE, MD. 21061

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Massive Pulmonary Embolus	45 min
	Due to (or as a consequence of):	
	b. Deep Venous Thrombosis	48 hr
	Due to (or as a consequence of):	
	c. Presumed Lung Cancer	2-3 mo.
	Due to (or as a consequence of):	
	d.	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month Day Year
1 [ ] Yes 2 [ ] No 9 [ ] Unknown	1 [ ] Live birth 2 [ ] Fetal death 3 [ ] Ectopic pregnancy 4 [ ] Pregnant at time of death 5 [ ] Other (specify) 9 [ ] Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Coronary Artery Disease

23e. Did tobacco use contribute to the cause of death?	24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown	1 [ ] Yes 2 [X] No	1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner?	28. Place of Death (Check only one)	
1 [X] Yes 2 [ ] No	Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA	Other: 4 [ ] Nursing Home 5 [ ] Residence 8 [ ] Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined		M	1 [ ] Yes 2 [X] No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ MD	D27720	3/22/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) James J. York, MD; 200 Hospital Dr Glen Burnie MD 21061

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
APR 03 2001	Geneva G Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification; To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No: 2001 10111

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): SAMUEL MCCULLOUGH

2. Date of Death — Month: April Day: 2, Year: 2001

3. Time of Death: 2:05 AM

4a. Facility Name (If not institution, give street and number): Sinai Hospital of Baltimore

4b. City, Town, or Location of Death: Baltimore City

4c. County of Death: N/A

Funeral Director

5. Social Security Number: 218-42-7818

6. Sex: 1☑M 2☐F

7. Age (In yrs. last birthday): 54 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): 10-19-1946

9. Birthplace (State or Foreign Country): MD

Usual Residence of Decedent

10a. State: MD

10b. County: BALTIMORE

10c. City, Town or Location: GWYNN OAK

10d. Inside City Limits: 1☐Yes 2☑No

10e. Street and Number: 1922 BROOKDALE ROAD

10f. Zip Code: 21244

10g. Citizen of What Country?: USA

11. Marital Status: 1☐Never Married 2☑Married 3☐Widowed 4☐Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐Yes 2☑No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☑No Specify:

14. Race - American Indian, Black, White, etc. Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 9TH GRADE

College (1-4or 5+): N/A

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): WINDOW CLEANER

16b. Kind of Business/Industry: CONTRACTOR

17. Father's Name (First, Middle, Last): IRA MCCULLOUGH

18. Mother's Name (First, Middle, Maiden Surname): RUBY MALONLEY

19a. Informant's Name/Relationship (Type, Print): HELEN MCCULLOUGH | WIFE

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1922 BROOKDALE RD., BALTO. MD. 21244

20a. Method of Disposition: 1☑Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)

20b. Place of Disposition (Name of cemetery, cremetory or other place): ARBUTUS CEMETERY

Date: 04-07-01

20c. Location - City or Town, State: BALTO. MD

21. Signature of Funeral Service Licensee: ▶ Vaughn C [illegible]

22. Name and Address of Facility: VAUGHN C. GREENE FUNERAL SERVICE 5151 BALTO. NATL PIKE, BALTO. MD. 21229

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. squamous cell carcinoma of the lung — 3 Months

Due to (or as a consequenca of):

Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Diseese or Injury that initiated events resulting in death) Last

b. chronic obstructive pulmonary disease

Due to (or as a consequenca of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☑Yes 2☐No 3☐Probably 4☐Unknown

24a. Was an autopsy performed? 1☐Yes 2☑No

24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☐No

25. Was case referred to medical examiner? 1☐Yes 2☑No

26. Place of Death (Check only one): Hospital: 1☑Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☐Residenca 6☐Other (Specify)

27. Manner of Death: 1☑Natural 2☐Accident 3☐Sulcide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐Yes 2☐No

28d. Describe how injury occurred

28e. Piece of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and placa, and due to the cause(s) and manner es stated. 2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Malka Blass, MD

29c. License number: RES 000

29d. Date signed (Month, Day, Year): April 2, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): MALKA BLASS MD

State Registrar

31. Date filed (Month, Day, Year): APR 0 3 2001

32. Registrar's Signature: ▶ Geneva G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 28a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

Samuel McCullough

Pt. known as:

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 10112

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Lillian Theola Miles

2. Date of Death (Month, Day, Year): March 31 2001

3. Time of Death: 4:48 a.m.

4a. Facility Name (If not institution, give street and number): Genesis ElderCare- Long Green

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: N/A

Funeral Director

5. Social Security Number: 244-22-5035

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 78 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Jan. 19, 1922

9. Birthplace (State or Foreign Country): South Car.

Usual Residence of Decedent

10a. State: MD

10b. County: N/A

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 851 Evesham Avenue

10f. Zip Code: 21212

10g. Citizen of What Country? USA

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: BLACK

15. Decedent's Education (Specify only highest grade completed): Elementery/Secondery (0-12): 11th . College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Home Maker

16b. Kind of Business/Industry: Own Home

17. Father's Nema (First, Middle, Last): Daniel Miles

18. Mother's Name (First, Middle, Maiden Surname): Helena UNKNOWN

19a. Informent's Name/Reletionship (Type, Print): Willa D. Cox-Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 851 Evesham Avenue Balto. MD 21212

20a. Mathod of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from Stete 4☐ Donetion 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Woodlawn Cemetery

Date: 04/04

20c. Location - City or Town, State: Woodlawn, MD

21. Signature of Funeral Service Licensee: Ernest R. Fenny, Jr.

22. Name and Address of Facility: Nutter Funeral Homes, Inc. 2501 Gwynns Falls Pkwy. Balto. MD 21216

Physician /Medical Examiner

23a. Part1. Enter the diseese, or complicetions thet caused the death. Do not enter the mode of dying, such es cardiac or respiratory errest, shock, or haert failure. List only one ceuse on each line.

Approximate Interval Between Onset and Death

Immediete Cause (Final diseese or condition resulting in deeth)
e. Sepsis — Days

Due to (or as a consequence of):
b. GANgrene of Lower Extremities — 3 to 4 weeks

Sequentially list conditions, if any, leeding to immediete cause. Enter Underlying Cause (Disease or Injury thet initieted events resulting in death) Last
c. Peripheral Vascular Disease — Years

Due to (or as e consequence of):
d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Dementia
Diabetes Mellitus

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Wes an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospitel: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Menner of Death: 1☐ Naturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined

28a. Dete of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Piece of Injury - At home, ferm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ Certifying Physician: To the best of my knowledge, death occurred et the time, date and place, and due to the cause(s) and manner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner steted.

29b. Signature and Title of certifier: Attending

29c. License number: D17118

29d. Date signed (Month, Day, Year): Apr 2, 2001

30. Name and eddress of person who completed cause of death (Item 23a) (Type, Print): Paul Schwartz M.D. 7700 York Rd 21204

State Registrar

31. Dete filed (Month, Day, Year): APR 03 2001

32. Registrar's Signature: Jeanne B Sparks

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 10113

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): EDWARD D McCOURRY
2. Date of Death (Month, Day, Year): MARCH 28 2001
3. Time of Death: 2:30 PM
4a. Facility Name (If not institution, give street and number): Good Samaritan Nursing Center
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 241 48 7512
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 66 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Nov. 11, 1934
9. Birthplace (State or Foreign Country): North Carolina

Usual Residence of Decedent

10a. State: MD
10b. County: Baltimore
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 1312 W. 37th Street
10f. Zip Code: 21211
10g. Citizen of What Country?: United States

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 9 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Carpenter
16b. Kind of Business/Industry: USF Consolation

17. Father's Name (First, Middle, Last): Carson McCourry
18. Mother's Name (First, Middle, Maiden Surname): Pansy Peterson

19a. Informant's Name/Relationship (Type, Print): Goldie McCourry/wife
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1312 W. 37th St. Baltimore, MD 21211

20a. Method of Disposition: 1 [ ] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [X] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Anatomic Gift Foundation | Date: 3/28/01
20c. Location - City or Town, State: Laurel, MD

21. Signature of Funeral Service Licensee: ▶ [signature]
22. Name and Address of Facility: Anatomic Gift Foundation 13948 Baltimore Ave. Laurel, MD 20707

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part1. Enter the disease, or complications that caused tha death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on aach fina.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition rasulting in death)
a. End Stage Renal disease — not known
Due to (or as a consequence of):

Sequentially list conditions, if any, laading to immediete cause. Entar Underlying Cause (Disease or injury that initiated events resulting in daath) Last
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No
26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | Other: 4 [X] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be datarmined
28a. Data of Injury (Month, Day Year)
28b. Tima of Injury
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician**: To tha best of my knowledge, death occurred at the time, data and place, and dua to the cause(s) and mannar as stated. 2 [ ] **Medical Examiner:** On the basis of axamination and/or investigation, in my opinion, death occurred at the time, date and place, and dua to tha cause(s) and mannar stated.
29b. Signature and title of certifier: ▶ Dmitri K. Tripuraneni
29c. License number: D30661
29d. Date signed (Month, Day, Year): April 3rd 2001
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Sreesh Tripuraneni 3601 Loch Raven Blvd, Baltimore, MD 21239.

State Registrar

31. Date filed (Month, Day, Year): APR 03 2001
32. Registrar's Signature: [signature] D Sparks

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Amended Item#2 perPHYG794 4/3/2001 EW

Certificate of Death

F... 2001 10114

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Margaret Elizabeth Moreth

2. Date of Death Month / Day / Year: Feb. 5 2001

3. Time of Death: 12:35 PM

4a. Facility Name *(If not institution, give street and number)*: Stella Maris Hospice

4b. City, Town, or Location of Death: Timonium

4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 058-32-5720

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 86 Yrs.

If Under 1 Yaar: Months / Deys

If Under 24 Hrs.: Hours / Min.

8. Dete of Birth *(Month, Day, Year)*: Nov. 8 1914

9. Birthplace *(Stete or Foreign Country)*: NY

Usuel Residence of Decedent

10a. Steta: MD

10b. County: n/a

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 619 W. 36th St.

10f. Zip Code: 21211

10g. Citizen of Whet Countfry?: USA

11. Maritel Stetus: 1☐ Navar Married 2☐ Merried 3☒ Widowed 4☐ Divorced

12. Was Decedent Evar in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yaar or Detas:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, atc.) 1☐ Yes 2☒ No *Specify:*

14. Reca - Amarican Indian, Bleck, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highast grada completed)*: Elementary/Secondery (0-12): 12; College (1-4or 5+): 3

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Nurse

16b. Kind of Business/Industry: Nursing

17. Fathar's Nema *(First, Middla, Last)*: Guy Sewell

18. Mother's Neme *(First, Middle, Maiden Surneme)*: Beatrice Smith

19a. Informent's Name/Relationship *(Type, Print)*: Susan Moreth/daughter

19b. Mailing Address *(Street and Number or Rural Routa Number, City or Town, State, Zip Code)*: 619 W. 36th St., Balto., MD 21211

20a. Mathod of Disposition: 1☐ Buriel 2☒ Cremetion 3☐ Removal from State 4☐ Donetion 5☐ Other *(Specify)*

20b. Piece of Disposition *(Neme of cemetery, cremetory or other place)*: Balto. Wash. Crematory

Dete: 2/8/01

20c. Location - City or Town, Stete: Laurel, MD

21. Signeture of Funeral Service Licensee: Bryan W. Clary

22. Name and Address of Facility: Lemmon Funeral Home 10 W. Padonia Rd., Timonium, MD 21093

Physician /Medical Examiner

23a. Part I. Enter the diseese, or complicetions that caused the deeth. Do not enter the mode of dying, such as cardiec or respiretory errest, shock, or heart feilura. List only one ceuse on each line.

Approximate Interval Between Onsat and Deeth

Immediata Causa (Finat diseese or condition resulting in deeth)

a. CHRONIC OBSTRUCTED PULMONARY DISEASE

Due to (or es a consequence of):

Sequentielly list conditions, if eny, leading to immediete cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or es a consequenca of):

c.

Due to (or es a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not rasulting in the underlying cause given in Part I.

23b. Did tobacco use contributa to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Wes an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings aveilable prior to completion of cause of death? 1☐ Yes 2☐ No

25. Wes casa referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpetient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 8☒ Other *(Specify)* HOSPICE

27. Menner of Death: 1☒ Naturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined

28a. Dete of Injury *(Month, Dey Year)*

28b. Time of Injury M

28c. Injury et Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Pleca of Injury - At home, ferm, street, fectory, office building, etc. *(Specify)*

28f. Location *(Street end Number or Rurel Route Number, City or Town, Stete)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Phyaician:** To the best of my knowledge, deeth occurred et the time, date and place, end due to the cause(s) and manner es stated. 2☐ **Medical Examiner:** On the basis of examinetion and/or investigetion, in my opinion, deeth occurred at the time, date and place, and due to the ceuse(s) and menner stated.

29b. Signetura and title of certifier:

29c. License number: D43725

29d. Dete signed *(Month, Day, Year)*: 2/6/01

30. Name and address of person who completed ceuse of deeth (Item 23a) (Type, Print): DR. TARIQ MAHMOOD 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093

State Registrar

31. Data filed *(Month, Day, Year)*: FEB 0 9 2001

32. Registrer's Signeture: Geneva G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

To be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

JANUARY 5, 2001 12:35 p.m.

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Medical Examiner or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Division of Vital Records, P.O. Box 68760,

MARGARET MORETH

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 10115

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Thelma M Menke

2. Date of Death: Month: April Day: 01 Year: 2001

3. Time of Death: 1840

4a. Facility Name (If not institution, give street and number): Good Samiritan Hospital

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 214-22-9797

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 89 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Aug 18, 1911

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: N/A

10c. City, Town or Location: Baltimore

10d. Inside City Limits: XX 1☒ Yes 2☐ No

10e. Street and Number: 2095 Rockrose Avenue

10f. Zip Code: 21211

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Nevar Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yas 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementery/Secondery (0-12): 12 | College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Retail Sales

16b. Kind of Business/Industry: Department Store

17. Father's Name (First, Middle, Last): George Watts

18. Mother's Name (First, Middle, Meiden Sumame): Flossie Foster

19a. Informant's Name/Ralationship (Type, Print): Charles Lindsay (Son)

19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 7 Lincoln Woods Way Apt 2B Perry Hall, MD 21128

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): St. Mary's Cemetery

Data: 4/5/01

20c. Location - City or Town, State: Baltimore, MD.

21. Signature of Funeral Service Licensee: ▶ Lynn B. Henss

22. Name and Address of Facility: Burgee-Henss-Seitz Funeral Home, Inc. 3631 Falls Road, Baltimore, Md. 21211

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiec or respiretory errest, shock, orheart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Hypoxia — Minutes

Due to (or as a consequence of):

b. Pneumonia — One Week

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated avents rasulting in death) Last

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not rasulting in the underlying cause given in Part I.

Atrial Fibrillation

23b. Did tobacco use contribute to the cause of death? 1☐ Yas 2☐ No 3☑ Probably 4☐ Unknown

24a. Wes an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of causa of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death (Check only one): Hospital: 1☑ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☑ Netural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rurel Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, data and placa, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Jack E Lewi, MD

29c. License number: D0056269

29d. Date signed (Month, Day, Year): April 01 2001

30. Nama and address of person who completed cause of death (Item 23a) (Type, Print): Jack E Lewi MD 5601 loch raven blvd. 21239

State Registrar

31. Date Rec'd (Month, Day, Year): APR 03 2001

32. Registrar's Signature: ▶ Penny G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

Burial, Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 10116

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)			2. Date of Death Month Day Year	3. Time of Death
ANNE	WILLIAMS	MILLER	MARCH 31, 2001	11:15 AM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
12 CHARLES ROAD	LINTHICUM	ANNE ARUNDEL

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
178-16-4696	1☐M 2☒F	81 Yrs.			OCT. 4, 1919	PENNSYLVANIA

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MARYLAND	ANNE ARUNDEL	LINTHICUM	1☐Yes 2☒No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
12 CHARLES ROAD	21090	U.S.A.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐Never Married 2☐Married 3☒Widowed 4☐Divorced	1☐Yes 2☒No If Yes, Give Year or Dates:	1☐Yes 2☒No Specify:	Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	18b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
	1	HOMEMAKER	OWN HOME

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
FRANK B. WILLIAMS	MARTHA SCHAFHART

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
MRS. MOLLY MYERS (DAUGHTER)	2687 WALSTON ROAD, MOUNT AIRY, MARYLAND 21771

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	CRESTLAWN MEMORIAL GARDENS	04/5/2001	MARRIOTTSVILLE, MD.

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶	SINGLETON FUNERAL HOME, P.A., 1 SECOND AVENUE, S.W., GLEN BURNIE, MD. 21061

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Acute myocardial infarction

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. Due to (or as a consequence of):

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐Yes 2☒No 9☐Unknown

23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fatal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown

23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☑No 3☐Probably 4☐Unknown

24a. Was an autopsy performed? 1☐Yes 2☑No

24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☐No

25. Was case referred to medical examiner? 1☐Yes 2☑No

28. Place of Death (Check only one)
Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA
Other: 4☐Nursing Home 5☑Residence 8☐Other (Specify)

27. Manner of Death 1☑Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
	M	1☐Yes 2☐No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1☑**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ B. BADRO, MD	D36384	4/2/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
BASSEM BADRO 7845 OAKWOOD RD. GLEN BURNIE, MD 21061

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
APR 03 2001	Jennie G Sparks

DHMH 17 Rev 1/2001

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification; To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 10117

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Norma J. Mangus
2. Date of Death (Month, Day, Year): March 28, 2001
3. Time of Death: 11:15am
4a. Facility Name *(If not institution, give street and number)*: 5161 Ilchester Road
4b. City, Town, or Location of Death: Ellicott City
4c. County of Death: Howard

Funeral Director

5. Social Security Number: 522-36-4574
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 71 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: 7-2-1929
9. Birthplace *(State or Foreign Country)*: Kansas

Usual Residence of Decedent

10a. State: Colorado
10b. County: Jefferson
10c. City, Town or Location: Denver
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 7101 West Yale Ave. #3401
10f. Zip Code: 80227
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No — If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* white

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 — College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: real estate agent
16b. Kind of Business/Industry: real estate

17. Father's Name *(First, Middle, Last)*: Glenn Riddell
18. Mother's Name *(First, Middle, Maiden Surname)*: Myrtle Ream

19a. Informant's Name/Relationship *(Type, Print)*: Becky Mangus - daughter
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 5161 Ilchester Rd., Ellicott City, Md. 21043

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Balt/Washington Crematory — Date: 3/30/01
20c. Location - City or Town, State: Laurel, Md.

21. Signature of Funeral Service Licensee: ▶ Wanda L Lemmer
22. Name and Address of Facility: Witzke Funeral Home of Catonsville, Inc. 1630 Edmondson Ave., Catonsville, Md. 21228

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. PANCREATIC CANCER — 6 months

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 6☒ Other *(Specify)* Daughter's home

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Keith Lillemoe MD
29c. License number: D24521
29d. Date signed *(Month, Day, Year)*: 3/29/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): KEITH D. LILLEMOE, JOHNS HOPKINS, 600 N. WOLFE ST., BALTIMORE, MD. 21287

State Registrar

31. Date filed *(Month, Day, Year)*: APR 03 2001
32. Registrar's Signature: ▶ Geneva G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 10118

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Lucille Pauline Mangan

2. Date of Death: Month April Day 1 Year 2001

3. Time of Death: 9:30 AM

4a. Facility Name *(If not institution, give street and number)*: LORIEN AT RIVERSIDE

4b. City, Town, or Location of Death: BELCAMP

4c. County of Death: HARFORD

Funeral Director

5. Social Security Number: 219-16-4992

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 76 Yrs.

If Under 1 Year: Months ____ Days ____

If Under 24 Hrs.: Hours ____ Min. ____

8. Date of Birth *(Month, Day, Year)*: June 14, 1924

9. Birthplace *(State or Foreign Country)*: Pennsylvania

Usual Residence of Decedent

10a. State: Md.

10b. County: Baltimore

10c. City, Town or Location: Parkville

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 2517 East Joppa Rd.

10f. Zip Code: 21234

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12; College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Materials Handler

16b. Kind of Business/Industry: Western Electric

17. Father's Name *(First, Middle, Last)*: Michael Raymond Moran

18. Mother's Name *(First, Middle, Maiden Surname)*: Mildred Gladys Miller

19a. Informant's Name/Relationship *(Type, Print)*: Mrs. Diane L. Pirisino/ Daughter

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 1025 Pirates Court Edgewood, Md. 21040

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Dulaney Valley Mem. Gdns.

Date: 4-5-01

20c. Location - City or Town, State: Timonium, Md.

21. Signature of Funeral Service Licensee: Kurt J. Pough

22. Name and Address of Facility: Ruck Towson Funeral Home, Inc. 1050 York Rd. Towson, Md. 21204

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. myocardial infarction

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

coronary artery disease, cerebrovascular accident

Congestive Heart Failure

Atrial Fibrillation Hypothyroidism

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Shaun McClure MD

29c. License number: D27975

29d. Date signed *(Month, Day, Year)*: 4/01/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): SHAUN McCLURE MD 615 Macphail Rd Bel Air, MD 21014

State Registrar

31. Date filed *(Month, Day, Year)*: APR 03 2001

32. Registrar's Signature: Geneva G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Lucille Mangan

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No: 2001 10119

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)		2. Date of Death Month Day Year	3. Time of Death
Sandra Messner		April 1, 2001	6:35 PM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Hospice Of Baltimore, Gilchrist Center	Towson	Baltimore

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
213-03-6293	1☐ M 2☒ F	81 Yrs.			July 14, 1919	Maryland

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	n/a	Baltimore	1☒ Yes 2☐ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
6711 Park Heights Ave. Apt. 102	21215	United States

11. Marital Status	12. Was Decedent Evar in U.S. Armed Forces?	13. Wes Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, atc.)	14. Race - American Indian, Bleck, White, etc.
1☐ Nevar Married 2☒ Married 3☐ Widowed 4☐ Divorced	1☐ Yes 2☒ No If Yes, Give Yeer or Detes:	1☐ Yes 2☒ No Specify:	Specify: white

15. Decedent's Education (Specify only highast grada compiated)		16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT usa retired)	16b. Kind of Business/Industry
Elementery/Secondery (0-12)	College (1-4or 5+)		
12		Homemaker	Own Home

17. Fathar's Nema (First, Middle, Last)	18. Mother's Nama (First, Middle, Maiden Surneme)
Carlo Tricario	Josephine Pardo

19a. Informent's Name/Reletionship (Type, Print)	19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stata, Zip Code)
Mr. Herbert Messner/Husband	6711 Park Heights Ave. Apt. 102 Baltimore, MD 21215

20a. Method of Disposition	20b. Piece of Disposition (Neme of cemetery, crematory or other piece)	Date	20c. Location - City or Town, Stete
1☐ Burial 2☐ Cramation 3☐ Removal from State 4☐ Donetion 5☒ Other (Specify) Entombment	Dulaney Valley Mem. Gard	04/05/01	Timonium, MD

21. Signature of Funeral Service Licensee	22. Neme and Address of Facility
Stephen Coster M01122	Ruck Towson Funeral Home, Inc. 1050 York Road Towson, Maryland 21204

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications thet caused the deeth. Do not enter the mode of dying, such as cardiec or respiretory errest, shock, or haert feilure. List only one cause on eech line.

		Approximate Interval Between Onset and Death
Immediete Ceuse (Final diseese or condition resulting in death)	a. gastric cancer	2 years
	Dua to (or as e consaquence of):	
Sequentially list conditions, if eny, leeding to immedieta cause. Entar Underlying Cause (Disease or Injury that initiated events resulting in death) Last	b.	
	Due to (or es a consequenca of):	
	c.	
	Dua to (or es a consequanca of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Dementia

23b. Did tobacco use contribute to the cause of death?	24a. Wes an autopsy performed?	24b. Wara eutopsy findings available prior to completion of causa of deeth?
1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown	1☐ Yes 2☒ No	1☐ Yes 2☐ No

25. Was casa referred to medicat examiner?	26. Piece of Death (Check only one)	
1☐ Yes 2☒ No	Hospitel: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA	Other: 4☐ Nursing Home 5☐ Residence 6☒ Other (Specify) Hospice

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicida 5☐ Pending investigetion 6☐ Could not be datarmined		M	1☐ Yas 2☐ No	

28e. Pleca of Injury - At homa, farm, street, factory, offica building, etc. (Specify)	28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one)
1☒ **Certifying Physician:** To the best of my knowledge, daeth occurred at tha time, date end place, end due to tha causa(s) and manner as stated.
2☐ **Medical Examiner:** On tha basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, date end placa, and dua to the cause(s) end mennar steted.

29b. Signatura end title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
W. Anthony Riley, MD	D25205	April 2, 2001

30. Neme and address of person who completed cause of death (Item 23a) (Type, Print)
W. A. Riley GBMC 6701 N. Charles St Balto. md 21204

State Registrar

31. Date filed (Month, Day, Year)	32. Registrer's Signature
APR 0 3 2001	Sandra G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

April 1, 2001 6:35PM.

Messner Sandra

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 10120

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Willie Mobley
2. Date of Death: Month MARCH Day 31 Year 2001
3. Time of Death: 7:15 AM
4a. Facility Name (If not institution, give street end number): HCR MANOR CARE TOWSON
4b. City, Town, or Location of Death: TOWSON
4c. County of Death: BALTIMORE

Funeral Director

5. Social Security Number: 249-07-8510
6. Sex: 1☒ M 2☐ F
7. Age (In yrs. last birthday): 88 Yrs. — If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): JULY 19, 1912
9. Birthplace (State or Foreign Country): S. CAROLINA

Usual Residence of Decedent

10a. State: Md.
10b. County: N/A
10c. City, Town or Location: BALTIMORE
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 3706 W. ROGERS AVENUE
10f. Zip Code: 21215
10g. Citizen of What Country?: U.S.A.

11. Meritel Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Wes Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify: X
14. Race - American Indian, Black, White, etc. Specify: AFRO-AMERICAN

15. Decedent's Educetion (Specify only highest grade completed): Elementery/Secondery (0-12): 5TH; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): BOTTOM MAKER
16b. Kind of Business/Industry: BETHLEHEM STEEL

17. Father's Name (First, Middle, Last): JAMES MOBLEY
18. Mother's Name (First, Middle, Maiden Surname): MAGGIE BEATTY

19e. Informent's Name/Reletionship (Type, Print): LULA SIMON (DAUGHTER)
19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1203 WISTERIA DRIVE CATONSVILLE, MD. 21228

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Piece of Disposition (Name of cemetery, crematory or other place): DRUID RIDGE CEM. Date: APRIL 4, 2001
20c. Location - City or Town, State: BALTIMORE CO, MD.

21. Signature of Funeral Service Licensee: Bernadine V. Scruggs
22. Name and Address of Facility: CALVIN B. SCRUGGS FUNERAL HOME 1412 E. PRESTON STREET BALTO, MD. 21213

Physician /Medical Examiner

23a. Part1. Enter the diseese, or complicetions thet caused the deeth. Do not enter the mode of dying, such es cardiac or respiretory errest, ahock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final diseese or condition resulting in death): a. Ischemic Heart Disease — years

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediete cause. Enter Underlying Ceuse (Disease or injury thet initieted events resulting in death) Last:
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Part I.: Multinfarct Dementia Dehydration

23b. Did tobacco uas contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24e. Was en eutopsy performed? 1☐ Yes 2☒ No
24b. Were eutopsy findings eveilable prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☒ Nursing Home 5☐ Residence 8☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year):
28b. Time of Injury: M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred:
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify):
28f. Location (Street and Number or Rurel Route Number, City or Town, State):

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and piece, end due to the ceuse(s) and manner es steted. 2☐ **Medical Examiner:** On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date end piece, end due to the cause(s) end menner stated.

29b. Signature and title of certifier: [illegible] M.D.
29c. License number: D08358
29d. Date signed (Month, Day, Year): APRIL 2 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): [illegible] 8903 HARTFORD ROAD BALT. MARYLAND 21234

State Registrar

31. Date filed (Month, Day, Year): APR 03 2001
32. Registrar's Signature: Lenora G. Sparks

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

DHMH 16 Rev 6/95

ORIGINAL

01-1641-510
crn
Charles McDonald

1- For State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 10121

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month	Day	Year	3. Time of Death
CHARLES A. McDONALD	March	24	2001	9:45 A M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
570 Wilson Street	Baltimore	N/A

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
226-30-6803	1 X M 2 F	72 Yrs.			1-16-1929	VIRGINIA

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD.	N/A	BALTIMORE	1 X Yes 2 No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
558 WILSON ST.	21217	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1 X Never Married 2 Married 3 Widowed 4 Divorced	1 Yes 2 X No If Yes, Give Year or Dates:	1 Yes 2 X No Specify:	Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
-12-	-0-	LABORER	STEEL

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
CHARLIE McDONALD	ALMA TAYLOR

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
JOY HAMILTON(DAUGHTER)	28 TEMONS CT. BALTIMORE, MARYLAND 21244

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)	GARRISON FOREST VETERANS	4-4-2001	OWINGS MILLS, MARYLAND

21. Signature of Funeral Service Licensee: Joseph D. Hosner

22. Name and Address of Facility: PHILLIPS FUNERAL HOME, P.A. 1721-27 N. MONROE ST. BALTIMORE, MARYLAND 21217

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Pneumonia	
	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b.	
	Due to (or as a consequence of):	
	c.	
	Due to (or as a consequence of):	
	d.	

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1 Yes 2 X No 9 Unknown

23c. If yes, outcome of pregnancy 1 Live birth 2 Felal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify) 9 Unknown

23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Lung Cancer
Hypertension

23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 X Unknown

24a. Was an autopsy performed? 1 X Yes 2 No

24b. Were autopsy findings available prior to completion of cause of death? 1 X Yes 2 No

25. Was case referred to medical examiner? 1 X Yes 2 No

26. Place of Death (Check only one)
Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA
Other: 4 Nursing Home 5 Residence 6 X Other (Specify) at scene

27. Manner of Death 1 X Natural 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined

28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
	M	1 Yes 2 No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification; To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one)
1 **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 X **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
Dennis J Chuteno	O.C.M.E.	March 30, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Dennis Chuteno 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
APR 0 3 2001	Steven G Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 10122

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Josephine H. Nelson

2. Date of Death (Month, Day, Year): April 1, 2001

3. Time of Death: 1:10 AM

4a. Facility Name *(If not institution, give street and number)*: Keswick Multi-Care Center

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: N/A

Funeral Director

5. Social Security Number: 215-09-3547

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 93 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Nov. 14, 1907

9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: N/A

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: Keswick Multi-Care Center 700 W. 40th Street

10f. Zip Code: 21211

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* white

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 8 / College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Homemaker

16b. Kind of Business/Industry: In Own Home

17. Father's Name *(First, Middle, Last)*: Charles Callahan

18. Mother's Name *(First, Middle, Maiden Surname)*: Mary Bodani

19a. Informant's Name/Relationship *(Type, Print)*: Phyllis Keehan Daughter

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 36 Margate Road Lutherville, MD 21093

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Meadowridge Mem. Park

Date: 4/4/01

20c. Location - City or Town, State: Elkridge, Maryland

21. Signature of Funeral Service Licensee: Mary Henss Carpenter

22. Name and Address of Facility: Burgee-Henss-Seitz Funeral Home, Inc. 3631 Falls Road Baltimore, MD 21211

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
e. progressive Dementia — years

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: W. Anthony Riley, MD

29c. License number: D25205

29d. Date signed *(Month, Day, Year)*: April 2, 2001

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): W.A. Riley GBMC 6701 N. Charles St. Balto. Md 21204

State Registrar

31. Date filed *(Month, Day, Year)*: APR 03 2001

32. Registrar's Signature: Barbara D Sparks

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Josephine Nelson 4-1-01 1:10 am

DHMH 16 Rev 6/95

ORIGINAL

RKD

01-1762-510

SOL MYRON NEWMEYER

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar AMEND ITEM 23a,27,28a-f per ME G794 SS

Certificate of Death

2001 10123

Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): SOL MYRON NEWMEYER

2. Date of Death Month Day Year: MARCH 30, 2001

3. Time of Death: 6:00P. M

4a. Facility Name (If not institution, give street and number): 1190 W.NORTHERN PARKWAY #704

4b. City, Town, or Location of Death: BALTIMORE

4c. County of Death: N/A

Funeral Director

5. Social Security Number: 220-05-0372

6. Sex: XX 1 M 2 F

7. Age (In yrs. last birthday): 79 Yrs.

If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): DEC.24,1921

9. Birthplace (State or Foreign Country): MD

Usual Residence of Decedent

10a. State: MD

10b. County: N/A

10c. City, Town or Location: BALTIMORE

10d. Inside City Limits: XX 1 Yes 2 No

10e. Street and Number: 1190 W. NORTHERN PARKWAY #704

10f. Zip Code: 21210

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 Never Married 2 Married XX 3 Widowed 4 Divorced

12. Was Decedent Ever in U.S. Armed Forces? XX 1 Yes 2 No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes XX 2 No Specify:

14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 5+ College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): INVESTMENT BANKER

16b. Kind of Business/Industry: FINANCE

17. Father's Name (First, Middle, Last): MORTON NEWMEYER

18. Mother's Name (First, Middle, Maiden Surname): DEAN GUTMAN

19a. Informant's Name/Relationship (Type, Print): ALAN GARTEN / ATTORNEY

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 36 S. CHARLES STREET #2300 - BALTIMORE, MD 21201

20a. Method of Disposition: XX 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): BALTIMORE HEBREW CEM

Date: 4/1/01

20c. Location - City or Town, State: BALTIMORE, MD

21. Signature of Funeral Service Licensee: Taylor

22. Name and Address of Facility: SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. SECOBARBITAL INTOXICATION

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown

23c. If yes, outcome of pregnancy: 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify) 9 Unknown

23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 Yes XX 2 No 3 Probably 4 Unknown

24a. Was an autopsy performed? 1 Yes XX 2 No

24b. Were autopsy findings available prior to completion of cause of death? 1 Yes XX 2 No

25. Was case referred to medical examiner? 1 X Yes 2 No

28. Place of Death (Check only one): Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 X Other (Specify) SCENE

27. Manner of Death: 1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 6 X Could not be determined

28a. Date of Injury (Month, Day Year): found: 3-30-01

28b. Time of Injury: found: 5:10 PM

28c. Injury at Work? 1 Yes 2 X No

28d. Describe how injury occurred: subject ingested drugs

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify): found at home

28f. Location (Street and Number or Rural Route Number, City or Town, State): 1190 W. NOrthern Pkwy, #704, Balto.,MD

29a. Certifier (Check only one): 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 X Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: J. M. Tims

29c. License number: O.C.M.E.

29d. Date signed (Month, Day, Year): MARCH 31, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): JACK M. TIMS, M.D. 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year): APR 03 2001

32. Registrar's Signature: Penny D Sparks

DHMH 17 Rev 1/2001

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification; To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print In Black Indellble Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 10124

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: WILLIAM A. NIEWIADOMSKI

2. Date of Death Month: 3 Day: 30 Year: 01

3. Time of Death: 10:40 AM

4a Facility Name *(If not institution, give street and number)*: M.C.I.H.

4b. City, Town, or Location of Death: HAGERSTOWN

4c. County of Death: WASHINGTON

Funeral Director

5. Social Security Number: 216-36-6580

6. Sex: 1 [X] M 2 [ ] F

7. Age *(In yrs. last birthday)*: 60 Yrs. If Under 1 Year: Months / Days. If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: 10/9/40

9. Birthplace *(State or Foreign Country)*: MD

Usual Residence of Decedent

10a. State: MD

10b. County: WASHINGTON

10c. City, Town or Location: HAGERSTOWN

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street end Number: 18601 ROXBURY RD.

10f. Zip Code: 21746

10g. Citizen of What Country?: USA

11. Marital Status: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced

12. Wes Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No *Specify:*

14. Raca - American Indian, Black, White, etc. *Specify:* WHITE

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 College (1-4or 5+): 0

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: PAINTER

16b. Kind of Business/Industry: PAINTING

17. Father's Name *(First, Middle, Last)*: ANDREW W. NIEWIADOMSKI

18. Mother's Name *(First, Middle, Maiden Surname)*: MARTHA CHACHULSKI

19a. Informant's Name/Relationship *(Type, Print)*: RITA MARCINIAK /SISTER

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 10002 W. ROSS AVE. PEORIA, ARIZONA 85382

20a. Method of Disposition: 1 [ ] Buriel 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: GREEN MOUNT CEME. Date: 4/2/01

20c. Location - City or Town, State: balto., md

21. Signeture of Funeral Service Licansee: Eugene Kaczorowski

22. Name and Address of Facility: KACZOROWSKI FUNERAL HOME P.A. 1201 DUNDALK AVE. BALTO., MD. 21222

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset end Death

Immediate Cause (Final disease or condition resulting in death)

a. SQUAMOUS CELL CANCER OF THE TONGUE

Due to (or as a consequenca of):

b. PULMONARY METASTSIS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequenca of):

c. BRAIN METASTASIS

Due to (or as a consequenca of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [X] Probably 4 [ ] Unknown

24a. Wes an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death *(Check only one)*: Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [X] Other *(Specify)* INFIRMARY

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, ferm, street, factory, office buiiding, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 [X] **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, date and placa, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigetion, in my opinion, death occurred at the time, dete end place, end due to the ceuse(s) end menner stated.

29b. Signeture end title of certifier: [illegible]

29c. License number: D 005-3055

29d. Dete signed *(Month, Day, Year)*: 3/30/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): S LAHAM 18601 ROXBURY RD HAGERSTOWN MD 21746

State Registrar

31. Date filed *(Month, Day, Year)*: APR 03 2001

32. Registrar's Signature: [illegible] B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

RJD
DELORIS MCNEW
01-1614-510

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

1- For State Registrar

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 10125

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: DOLORES L. Mc NEW
2. Date of Death: Month MARCH Day 23, Year 2001
3. Time of Death: 0640A. M
4a. Facility Name *(If not institution, give street and number)*: 106 S. EAST AVE.
4b. City, Town, or Location of Death: BALTIMORE
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 217-18-6223
6. Sex: 1☐M 2☒F
7. Age *(In yrs. last birthday)*: 76 Yrs.
If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: 11/29/24
9. Birthplace *(State or Foreign Country)*: MD

Usual Residence of Decedent

10a. State: MD
10b. County: N/A
10c. City, Town or Location: BALTIMORE
10d. Inside City Limits: 1☒Yes 2☐No
10e. Street and Number: 106 S. EAST AVE.
10f. Zip Code: 21224
10g. Citizen of What Country?: USA

11. Marital Status: 1☐Never Married 2☒Married 3☐Widowed 4☐Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐Yes 2☒No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify* WHITE

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 8; College (1-4or 5+): 0
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: HOMEMAKER
16b. Kind of Business/Industry: HOME

17. Father's Name *(First, Middle, Last)*: FRANCK SUPERCZYNSKI
18. Mother's Name *(First, Middle, Maiden Surname)*: LAURA RUTKOWSKA

19a. Informant's Name/Relationship *(Type, Print)*: WILLIAM McNEW JR. /HUSBAND
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 106 S. EAST AVE. BALTO., MD. 21224

20a. Method of Disposition: 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: ST. STANISLAUS
Date: 3/26/01
20c. Location - City or Town, State: BALTO., MD.

21. Signature of Funeral Service Licensee: ▶ Charles Kaczorowski
22. Name and Address of Facility: KACZOROWSKI FUNERAL HOME P.A. 1201 DUNDALK AVE. BALTO., MD. 21222

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. HEAD INJURIES

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. Due to (or as a consequence of):

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐Yes 2☒No 9☐Unknown
23c. If yes, outcome of pregnancy: 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other *(specify)* 9☐Unknown
23d. Date of delivery: Month Dey Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: METASTATIC SMALL CELL LUNG CANCER

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☒Unknown

24a. Was an autopsy performed? 1☒Yes 2☐No
24b. Were autopsy findings available prior to completion of cause of death? 1☒Yes 2☐No

25. Was case referred to medical examiner? 1☒Yes 2☐No

26. Place of Death *(Check only one)*: Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☒Residence 6☐Other *(Specify)*

27. Manner of Death: 1☐Netural 2☒Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

28a. Date of Injury *(Month, Day Year)*: 3/23/01 FOUND
28b. Time of Injury: FOUND 0615 M
28c. Injury at Work? 1☐Yes 2☒No
28d. Describe how injury occurred: SUBJECT FELL DOWN STAIRS
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*: AT HOME
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*: 106S. EAST AVE, BALTIMORE, MD

Medical Certification; To Be Completed by Physician/Medical Examiner

29a. Certifier *(Check only one)*: 1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☒ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ M.D.
29c. License number: O.C.M.E.
29d. Date signed *(Month, Day, Year)*: MARCH 23, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): MARY C. RIPPLE, M.D. 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed *(Month, Day, Year)*: APR 03 2001
32. Registrar's Signature: ▶

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 10126

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Mary Dorothy Olson

2. Date of Death: Month: April; Day: 2; Year: 2001

3. Time of Death: 10:05 am.

4a. Facility Name *(If not institution, give street and number)*: 405 Valley Meadow Circle Apt. A3

4b. City, Town, or Location of Death: Reisterstown

4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 163-07-3403

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 90 Yrs.

If Under 1 Year: Months; Days

If Under 24 Hrs.: Hours; Min.

8. Date of Birth *(Month, Day, Year)*: Dec. 17, 1910

9. Birthplace *(State or Foreign Country)*: Pennsylvania

Usual Residence of Decedent

10a. State: Maryland

10b. County: Baltimore

10c. City, Town or Location: Reisterstown

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 405 Valley Meadow Circle Apt. A3

10f. Zip Code: 21136

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedant of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12; College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Book Keeper

16b. Kind of Business/Industry: Jewelry Co.

17. Father's Name *(First, Middle, Last)*: Harry Ruffee

18. Mother's Name *(First, Middle, Maiden Surname)*: Etta L. Stratton

19a. Informant's Name/Relationship *(Type, Print)*: Harry Olson - son

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 4500 Chaucer Way, Unit 401, Owings Mills, Md. 21117

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Metro Crematory

Date: April 3, 2001

20c. Location - City or Town, State: Baltimore, Md.

21. Signature of Funeral Service Licensee: J. Garth Eckhardt

22. Name and Address of Facility: Eckhardt Funeral Chapel P.A. 11605 Reisterstown Rd. Owings Mills, Md. 21117

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart failura. List only one causa on each lina.

Approximate Interval Between Onset and Death

Immediate Causa (Final disease or condition resulting in death): a. Metastatic Colon Carcinoma

Due to (or as a consequenca of):

Sequentially list conditions, if any, leading to immediate causa. Enter Underlying Cause (Disaase or injury that initiated events resulting in death) Last

b.

Due to (or as a consequenca of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☒ Residance 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be datarmined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28a. Place of Injury - At homa, farm, straat, factory, offica building, afc. *(Specify)*

28t. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledga, daath occurred at the time, date and placa, and due to the cause(s) and mannar as stated. 2☐ **Medical Examiner:** On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and mannar stated.

29b. Signature and title of certifier: Kenneth Glick MD

29c. License number: D23679

29d. Date signed *(Month, Day, Year)*: 04-02-2001

30. Name and address of person who compiated causa of death (Item 23a) (Type, Print): Kenneth L. Glick, MD 90 Painters Mill Suite 126 Owings Mills, Maryland 21117

State Registrar

31. Date filed *(Month, Day, Year)*: APR 03 2001

32. Registrar's Signature: [signature] Sparks

MAY [illegible] 2002

ORIGINAL

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or items 23a or 28d show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 | 10127

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): John Leonard Olson
2. Date of Death (Month, Day, Year): March 31, 2001
3. Time of Death: 7:13 AM
4a. Facility Name (If not institution, give street and number): Joseph Richey Hospice
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 219-70-6050
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 47 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): JAN 5, 1954
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Anne Arundel
10c. City, Town or Location: Glen Burnie
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 332 Gatewater Court Apt. 202
10f. Zip Code: 21060
10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Electrician
16b. Kind of Business/Industry: Electrical Contracting

17. Father's Name (First, Middle, Last): Leonard Olson
18. Mother's Name (First, Middle, Maiden Surname): Aileen Kane

19a. Informant's Name/Relationship (Type, Print): Margaret Mary Olson/Wife
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 332 Gatewater Court Apt.202 Glen Burnie, MD 21060

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Metro Crematory Inc.
Date: 4-2-01
20c. Location - City or Town, State: Baltimore, MD

21. Signature of Funeral Service Licensee: Dawn F. McDonald
22. Name and Address of Facility: Cremation Society of MD, Inc. 299 Frederick Road Baltimore, MD 21228

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

7:13 Am.

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
e. Carcinoma of the lung — 10 mo

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [ ] No
26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 8 [X] Other (Specify) Hospice

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

John Olson March 31, 2001

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: John N. Payne M.D.
29c. License number: D 13012
29d. Date signed (Month, Day, Year): April 1, 01
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): John Payne 6565 N. Charles St. 21204

5

State Registrar

31. Date filed (Month, Day, Year): APR 0 3 2001
32. Registrar's Signature: Geneva G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 10128

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Dennis Dominic O'Leary
2. Date of Death — Month: March Day: 30 Year: 2001
3. Time of Death: 0640AM
4a. Facility Name *(If not institution, give street and number)*: Mariner Health of Catonsville
4b. City, Town, or Location of Death: Catonsville
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 216-20-1180
6. Sex: 1 ☒ M 2 ☐ F
7. Age *(In yrs. last birthday)*: 74 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: Aug. 19, 1926
9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Penn.
10b. County: Reading
10c. City, Town or Location: Sinking Spring
10d. Inside City Limits: 1 ☐ Yes 2 ☒ No
10e. Street and Number: 2 Charles Blvd. Rd. 12
10f. Zip Code: 19608
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☒ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☒ Yes 2 ☐ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, spacify Cuban, Mexican, Puerto Rican, etc.): 1 ☐ Yes 2 ☒ No *Specify:*
14. Rece - American Indian, Black, White, etc. *Specify:* White
15. Decedent's Education *(Specify only highest grade completed)*: Elementery/Secondary (0-12): 12 College (1-4or 5+): 0
16a. Decedent's Usuel Occupetion *(Give kind of work done during most of working life. DO NOT use retired)*: Engineer
16b. Kind of Business/Industry: Electrical
17. Father's Neme *(First, Middle, Last)*: Dennis O'Leary
18. Mother's Name *(First, Middle, Meiden Surneme)*: Unknown
19a. Informant's Name/Relationship *(Type, Print)*: Lillian E. O'Leary/ Ex-Wife
19b. Mailing Address *(Street end Number or Rural Route Number, City or Town, Stete, Zip Code)*: 202 W. Elpin Drive, Catonsville, Maryland 21228
20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other *(Specify)*
20b. Place of Disposition *(Neme of cemetery, crematory or other piece)*: Dulaney Valley — Dete: 4/2/2001
20c. Location - City or Town, State: Timonium, Maryland
21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: Hubbard Funeral Home, Inc. 4107 Wilkens Avenue, Baltimore, Maryland 21229

Physician /Medical Examiner

23e. Part1. Enter the diseese, or complications thet ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feilure. List only one ceuse on eech line.

		Approximete Interval Between Onset and Death
Immediete Ceuse (Final disease or condition resulting in deeth) e.	Cerebrovascular accident (Left MCA territory)	8weeks
Due to (or as e consequence of):		
Sequentially list conditions, if any, leading to immediete ceuse. Enter Underlying Cause (Diseese or Injury thet initieted events resulting in deeth) Lest b.	Hypertension	Years
Due to (or as e consequence of):		
c.	Coronary artery disease	Years
Due to (or as e consequence of):		
d.		

Part II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Part I.: Diabetes mellitus

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown

24e. Wes en eutopsy performed? 1 ☐ Yes 2 ☑ No

24b. Were autopsy findings eveileble prior to completion of ceuse of death? 1 ☐ Yes 2 ☑ No

25. Was cese referred to medical examiner? 1 ☐ Yes 2 ☑ No

26. Piece of Death *(Check only one)*: Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA — Other: 4 ☑ Nursing Home 5 ☐ Residence 6 ☐ Other *(Specify)*

27. Manner of Death: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury
28c. Injury et Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street end Number or Rurel Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 ☑ **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, dete end piece, and due to the ceuse(s) end menner as steted. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, deeth occurred et the time, date end piece, and due to the ceuse(s) and menner stated.

29b. Signature end title of certifier: [signature] physician
29c. License number: D52544
29d. Date signed *(Month, Day, Year)*: Mar 30, 2001

30. Neme and eddress of person who completed ceuse of death (Item 23e) (Type, Print): Benjamin S. Lee, M.D., 700 Geipe Rd, #204, Catonsville, MD 21228

State Registrar

31. Date filed *(Month, Dey, Yeer)*: APR 03 2001
32. Registrar's Signature: Geneva G Sparks

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To Be Completed by Funeral Director

permit. Pages 1 end 2 should be filed within 72 hours after death with the Maryland Department of Health end Mental Hygiene. **Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician end completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 10129

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): DEBORAH O'BRIEN
2. Date of Death: Month MARCH Day 31, Year 2001
3. Time of Death: 23:45p
4a. Facility Name (If not institution, give street and number): The Johns Hopkins Hospital
4b. City, Town, or Location of Death: Baltimore City
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 214-64-5030
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 47 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Feb. 10, 1954
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Baltimore
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 1923 Victory Drive
10f. Zip Code: 21227
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+): 2
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Registered Nurse
16b. Kind of Business/Industry: Health Care

17. Father's Name (First, Middle, Last): Peter Joseph Brankovich
18. Mother's Name (First, Middle, Maiden Surname): Anna Ruth Showalter

19a. Informant's Name/Relationship (Type, Print): Steven M. O'Brien/ Husband
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1923 Victory Drive, Baltimore, Maryland 21227

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Loudon Park Cemetery
Date: 4/4/2001
20c. Location - City or Town, State: Baltimore, Maryland

21. Signature of Funeral Service Licensee: Juanita R. Thomas
22. Name and Address of Facility: Hubbard Funeral Home, Inc. 4107 Wilkens Avenue, Baltimore, Maryland 21229

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. LEUKEMIA — > ONE YEAR

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day, Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Asst: A. SALEH, MD / PHYSICIAN
29c. License number: RES-000
29d. Date signed (Month, Day, Year): MARCH 31, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): A. SALEH - 600 NORTH WOLFE STREET. BALTIMORE, MD 21287.

State Registrar

31. Date filed (Month, Day, Year): APR 03 2001
32. Registrar's Signature: Jennie G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 10130

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Mildred Freda Onion
2. Date of Death: Month April Day 1 Year 2001
3. Time of Death: 1:45 a.m.
4a. Facility Name (If not institution, give street and number): Genesis Heritage
4b. City, Town, or Location of Death: Dundalk
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 212-20-4136
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 86 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 1/21/15
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Baltimore
10c. City, Town or Location: Dundalk
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 8330 Bletzer Road
10f. Zip Code: 21222
10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 5 years; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker
16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): Frederick Hayes
18. Mother's Name (First, Middle, Maiden Surname): Viola Finnegan

19a. Informant's Name/Relationship (Type, Print): Sharon Sellers (Friend)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 8330 Bletzer Road Dundalk, Maryland 21222

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Hilltop Serv. Corp.
Date: 4/3/01
20c. Location - City or Town, State: Towson, Maryland

21. Signature of Funeral Service Licensee: Stephanie Massey
22. Name and Address of Facility: Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Avenue Dundalk, Maryland 21222

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. CORONARY ARTERY DISEASE
Due to (or as a consequence of):
b. ATRIAL FIBRILLATION
Due to (or as a consequence of):
c. CONGESTIVE HEART FAILURE
Due to (or as a consequence of):
d. MALNUTRITION

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☑ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☑ Nursing Home 5☐ Residence 8☐ Other (Specify)

27. Manner of Death: 1☐ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of *my* knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in *my* opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Savinder K Tulla M.D
29c. License number: D27188
29d. Date signed (Month, Day, Year): 4/2/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Savinder K Tulla 2 Market Place Baltimore MD 21202

State Registrar

31. Date filed (Month, Day, Year): APR 0 3 2001
32. Registrar's Signature: Lorraine G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar ADMEND ITEM: #19B PER F.H. G794 4-2-01 MR

Certificate of Death

Reg. No. 2001 10131

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)		2. Data of Death Month / Day / Year	3. Time of Death
ELIZABETH	OWENS	April 01, 2001	6:10 AM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
JOHNS HOPKINS BAYVIEW MEDICAL CENTER	BALTIMORE	BALTIMORE CITY

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Data of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
214-22-0986	1☐M 2☒F	87 Yrs.			May 25, 1913	Maryland

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Baltimore	Dundalk	1☐Yes 2☒No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
18 Portship	21222	United States

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐Never Married 2☐Married 3☒Widowed 4☐Divorced	1☐Yes 2☒No If Yes, Give Year or Dates:	1☐Yes 2☒No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	18b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12 years		Housewife	Own Home

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
John L. Dantoni	Elizabeth Clara Blotkamp

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
George H. Owens, Jr. (Son)	2310 Township Road Dundalk, Maryland 21222

20a. Method of Disposition	20b. Place of Disposition (Name of cemetary, crematory or other place)	Data	20c. Location - City or Town, State
1☐Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☒Other (Specify) Entombment	Oak Lawn Cemetery	4/3/01	Baltimore, Maryland

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
Stephanie Massey	Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Avenue Dundalk, Maryland 21222

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Stroke	DAYS
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of): b. Atrial fibrillation	YEARS
	Due to (or as a consequence of): c.	
	Due to (or as a consequence of): d.	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month / Day / Year
1☐Yes 2☒No 9☐Unknown	1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Pneumonia, coronary artery disease

23a. Did tobacco use contribute to the cause of death?	24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐Yes 2☐No 3☐Probably 4☒Unknown	1☐Yes 2☒No	1☐Yes 2☐No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐Yes 2☒No	Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA	Other: 4☐Nursing Home 5☐Residence 8☐Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined		M	1☐Yes 2☐No	
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
Jason D. Rosenberg MD	RES-000	April 01, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Jason D. Rosenberg MD, JHBMC, 4940 Eastern Avenue Baltimore, MD 21224

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
APR 03 2001	G Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 28a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification; To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 10132

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month / Day / Year	3. Time of Death
ROY A PLOTT	March 31 2001	4:45 A.M.

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
VAMHCS FORT HOWARD DIVISION	FORT HOWARD	BALTIMORE

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
228-10-4395	XX 1 M 2 F	88 Yrs.			Oct. 28, 1912	Virginia

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	Baltimore	Essex	1 ☐ Yes 2 ☒ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
301 Stemmers Run Road	21221	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.)	14. Rece - American Indien, Black, White, etc.
1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☒ Yes 2 ☐ No If Yes, Give Year or Dates:	1 ☐ Yes 2 ☒ No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
6th		Carpenter	Ellicott Mech. Co.

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
William Plott	Sheppie Hall

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Leola D Plott / wife	301 Stemmers Run Road Baltimore MD. 2122

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	Gardens of Faith	4/3/01	Rossville MD

21. Signature of Funeral Service Licensee: ▶ R. Terry Connelly

22. Name and Address of Facility: Connelly Funeral Home of Essex 300 Mace Ave Baltimore MD. 21221

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. ALZHEIMER'S DEMENTIA	Years
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of): b. CARDIOMYOPATHY	Years
	Due to (or as a consequence of): c. CHRONIC OBSTRUCTIVE PULMONARY DISEASE	Years
	Due to (or as a consequence of): d.	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month / Day / Year
1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) _____ 9 ☐ Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☒ No	1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No

28. Place of Death (Check only one): Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA; Other: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
	M	1 ☐ Yes 2 ☐ No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ George E. Wicks III M.D.	D41365	March 31, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): GEORGE E. WICKS III, M.D. 9600 NORTH POINT ROAD, FORT HOWARD, MD 21052

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
APR 03 2001	▶

DHMH 17 Rev 1/2001

PLOTT, ROY A.

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or Items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completed, filed in by the funeral director, page 2 should be detached for use as the burial-transit

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 10133

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Aymen Parvin
2. Data of Death Month: 4 Day: 1 Year: 2001
3. Time of Death: 11:00 am
4a. Facility Name *(If not institution, give street and number)*: University of Maryland Medical System
4b. City, Town, or Location of Death: Baltimore
4c. County of Death:

Funeral Director

5. Social Security Number: NA
6. Sex: 1☐ M 2☑ F
7. Age *(In yrs. last birthday)* Yrs.: If Under 1 Year Months: Days: 5; If Under 24 Hrs. Hours: Min.:
8. Date of Birth *(Month, Day, Year)*: 3/26/01
9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: MD
10b. County: NA
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1☑ Yes 2☐ No
10e. Street and Number: 2106 Wilkens Ave
10f. Zip Code: 21223
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☑ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☑ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☑ No Specify:
14. Race - American Indian, Black, White, etc. Specify: Asian

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): NA; College (1-4or 5+): NA
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: NA
16b. Kind of Business/Industry: NA

17. Father's Name *(First, Middle, Last)*: Khawaja Abdul Hakeem
18. Mother's Name *(First, Middle, Maiden Surname)*: Tahira Parvin

19a. Informent's Name/Relationship *(Type, Print)*: Tahira Parvin / Mother
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 2106 Wilkens Avenue, Baltimore, MD 21223

20a. Method of Disposition: 1☑ Burial 2☐ Cramation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: King Memorial Park
Date: 4-2a
20c. Location - City or Town, State: Randallstown, MD

21. Signature of Funeral Service Licensee: Lynette K. Jones
22. Name and Address of Facility: Mgech F/H West 4300 Wabash Ave. Balto MD 21215

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Pulmonary Hemorrhage

Due to (or as a consequence of):
b. Respiratory Distress Syndrome

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):
c. Sepsis

Due to (or as a consequence of):
d. Patent Ductus Arteriosus

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No
26. Place of Death *(Check only one)*: Hospital: 1☑ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*
27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Adora Nwodi MD
29c. License number: AU417643501399
29d. Date signed *(Month, Day, Year)*: 4/1/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Adora Nwodi
Dept. of Pediatrics, 22 S. Greene Street, Baltimore, MD 21201

State Registrar

31. Date filed *(Month, Day, Year)*: APR 03 2001
32. Registrar's Signature: Denise G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

Amend Item 20bperFHG79404/03/01dhb

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 10134

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Eunice A. Poole

2. Date of Death (Month, Day, Year): MARCH 30 2001

3. Time of Death: 7 50 pm

4a. Facility Name (If not institution, give street and number): LARIEN AT RIVERSIDE

4b. City, Town, or Location of Death: BELCAMP

4c. County of Death: HARFORD

Funeral Director

5. Social Security Number: 217-09-3505

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 81 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): April 10, 1919

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Harford

10c. City, Town or Location: Abingdon

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 918 Hamburg Drive

10f. Zip Code: 21009

10g. Citizen of What Country? USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 11th Grade

College (1-4or 5+): N/A

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Check Inspector

16b. Kind of Business/Industry: American BankStationary

17. Father's Name (First, Middle, Last): Roger Bailey

18. Mother's Name (First, Middle, Maiden Surname): Eunice Hurley

19a. Informant's Name/Relationship (Type, Print): Deborah Anderson/Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 918 Hamburg Drive Abingdon MD 21009

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Hilltop Service Corp.

Date: 4/02/01

20c. Location - City or Town, State: Towson, Maryland

21. Signature of Funeral Service Licensee: Christina L. Hilton

▶ Christina L. Hilton

22. Name and Address of Facility: Leonard J. Ruck, Inc. 5305 Harford Road Baltimore MD 21009

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Eunice A. Poole

Baltimore, Maryland 21215-0020

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Chronic Renal Failure — 2 months

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Nephrosclerosis

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Severe Dementia

Cerebrovascular Accident

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☑ No

Medical Certification: To Be Completed by Physician/Medical Examiner

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death (Check only one)

Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA

Other: 4☑ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ MD

29c. License number: D19583

29d. Date signed (Month, Day, Year): March 31, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): MANUEL M. LAZATIN MD 8 Law Street, Aberdeen, Maryland 21001

State Registrar

31. Date filed (Month, Day, Year): APR 03 2001

32. Registrar's Signature: ▶ Geneva G Sparks

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Division of Vital Records, P.O. Box 68760,

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 10135

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Lucy PREAS
2. Date of Death Month: April Day: 2 Year: 2001
3. Time of Death: 21:35
4a. Facility Name (If not institution, give street and number): The Johns Hopkins Hospital
4b. City, Town, or Location of Death: Baltimore City
4c. County of Death: Baltimore City

Funeral Director

5. Social Security Number: 411-56-2635
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 80 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): March 24 1921
9. Birthplace (State or Foreign Country): TN

Usual Residence of Decedent

10a. State: TN
10b. County: Washington
10c. City, Town or Location: Johnson City
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 1301 Buffalo Street
10f. Zip Code: 37604
10g. Citizen of What Country?: United States

11. Meritel Stetus: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Wes Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yeer or Detes:
13. Wes Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - Americen Indien, Bleck, White, etc. Specify: White

15. Decedent's Educetion (Specify only highest grade completed): Elementery/Secondary (0-12): | College (1-4or 5+): 5+
16a. Decedent's Usuel Occupation (Give kind of work done dunng most of working life. DO NOT use retired): Nurse
16b. Kind of Business/Industry: Anesthetist

17. Father's Neme (First, Middle, Last): Charles B. Jones
18. Mother's Neme (First, Middle, Maiden Surneme): Blanche Propst

19a. Informent's Neme/Relationship (Type, Print): Dr. Hugh Preas son
19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code): 4010 Beverly Road Rockville, MD 20853

20a. Method of Disposition: 1☒ Buriel 2☐ Cremetion 3☐ Removel from Stete 4☐ Donetion 5☐ Other (Specify)
20b. Piece of Disposition (Neme of cemetery, cremetory or other piece): Montevista Burial Park
Dete: 4/7/2001
20c. Location - City or Town, Stete: Johnson City, TN

21. Signeture of Funerel Service Licensee: Jamar B Conley
22. Neme and Address of Fecility: Burrier-Queen Funeral Directors, P.A. 1212 W. Old Liberty Road Winfield, MD 21784

Physician /Medical Examiner

23a. Pert I. Enter the disease, or complications thet ceused the death. Do not enter the mode of dying, such es cardiac or respiretory srrest, shock, or heert feilure. List only one ceuse on eech line.

Approximate Interval Between Onset and Death

Immediete Cause (Finat diseese or condition resulting in death): a. Pneumonitis — 2 weeks

Due to (or as a consequence of):

Sequentially list conditions, if any, leeding to immediete cause. Enter Underlying Cause (Disease or injury thet initieted events resulting in deeth) Last:
b. Amiodarone Toxicity — 2 weeks
Due to (or es a consequence of):
c. Atrial Fibrillation
Due to (or as a consequence of):
d.

Pert II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Pert I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Wes an eutopsy performed? 1☐ Yes 2☒ No
24b. Were eutopsy findings available prior to completion of ceuse of death? 1☐ Yes 2☒ No

25. Was case referred to medicel examiner? 1☐ Yes 2☒ No
26. Place of Deeth (Check only one): Hospitel: 1☒ Inpetient 2☐ ER/Outpetient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Menner of Deeth: 1☒ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined
28a. Dete of Injury (Month, Dey Yeer)
28b. Time of injury M
28c. Injury et Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Piece of injury - At home, ferm, street, fectory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

29e. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, dete end place, and due to the cause(s) and menner as stated. 2☐ **Medical Examiner:** On the basis of exemination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner steted.

29b. Signeture end title of certifier: DW Berkenblit
29c. License number: RES 000
29d. Date signed (Month, Day, Year): APRIL 2, 2001

30. Neme and address of person who completed cause of death (Item 23a) (Type, Print): Gail Berkenblit 600 North Wolfe St 21287 JOHNS HOPKINS HOSPITAL, BALTIMORE MD

State Registrar

31. Date filed (Month, Day, Year): APR 03 2001
32. Registrar's Signeture: Donna G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

5

10

01-1740-003
B.K.S
CHARLES M. PARROTT

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 10136

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)			2. Date of Death Month	Day	Year	3. Time of Death
CHARLES	MICHAEL	PARROTT	MARCH	28,	2001	2038 P M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
NORTH ARUNDEL HOSPITAL	GLEN BURNIE	ANNE ARUNDEL

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
218-21-1929	1 X M 2 F	17 Yrs.			DEC. 9, 1983	MARYLAND

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MARYLAND	ANNE ARUNDEL	GLEN BURNIE	1 Yes 2 X No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
328 NEW JERSEY AVENUE, N.E.	21060	U.S.A.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1 X Never Married 2 Married 3 Widowed 4 Divorced	1 Yes 2 XX No If Yes, Give Year or Dates:	1 Yes 2 XX No Specify:	Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12		STUDENT	

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
FRANK PARROTT	PATRICIA COLEMAN

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
MR. FRANK PARROTT (FATHER)	328 NEW JERSEY AVENUE, N.E., GLEN BURNIE, MD. 21060

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1 XX Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)	GLEN HAVEN MEMORIAL PARK	3/31/2001	GLEN BURNIE, MD.

21. Signature of Funeral Service Licensee ▶ [signature] M00795

22. Name and Address of Facility SINGLETON FUNERAL HOME, P.A., 1 SECOND AVENUE, S.W., GLEN BURNIE, MD. 21061

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. MULTIPLE INJURIES	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of): b.	
	Due to (or as a consequence of): c.	
	Due to (or as a consequence of): d.	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month Day Year
1 Yes 2 No 9 Unknown	1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify) 9 Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?	24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1 Yes 2 ✓ No 3 Probably 4 Unknown	1 ✓ Yes 2 No	1 ✓ Yes 2 No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1 X Yes 2 No	Hospital: 1 Inpatient XX ER/Outpatient 3 DOA	Other: 4 Nursing Home 5 Residence 6 Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1 Natural 2 ✓ Accident 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined	3-28-01	2009 P M	1 Yes 2 ✓ No	BICYCLE DRIVER STRUCK BY TWO VEHICLES

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)
ROADWAY	RITCHIE HWY GLEN BURNIE MD

Medical Certification; To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one)
1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 X **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ [signature] M.E.	O.C.M.E	MARCH 29, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
MARYLAND A. KOREN 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
APR 0 3 2001	[signature] G Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 | 0137

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)		2. Date of Death Month Day Year	3. Time of Death
SYLVIA	PRISTOOP	MARCH 30, 2001	5:00 AM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
6238 ROBIN HILL ROAD	BALTIMORE	BALTIMORE

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
212-09-8262	1☐M 2☒F	89 Yrs.			APR. 22, 1911	RUSSIA

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	BALTIMORE	BALTIMORE	1☐Yes 2☒No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
6238 ROBIN HILL ROAD	21207	U.S.A.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐Never Married 2☒Married 3☐Widowed 4☐Divorced	1☐Yes 2☒No If Yes, Give Year or Dates:	1☐Yes ☒No Specify:	Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
	1	ACCOUNTANT	ACCOUNTING

17. Father's Name (First, Middle, Last)		18. Mother's Name (First, Middle, Maiden Surname)	
HILLEL	SHUVALSKY	SARAH	KUTCHER

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
NATHAN PRISTOOP / HUSBAND	6238 ROBIN HILL ROAD - BALTIMORE, MD 21207

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	MOSES MONTEFIORE	4/1/2001	BALTIMORE, MD

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶	SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. cerebrovaocular accident	30 days
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of): b. myocardial infarction	30 days
	Due to (or as a consequence of): c. Hypertension	
	Due to (or as a consequence of): d.	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month Day Year
1☐Yes 2☒No 9☐Unknown	1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?	24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐Yes 2☐No 3☐Probably 4☒Unknown	1☐Yes 2☒No	1☐Yes 2☐No

Medical Certification: To Be Completed by Physician/Medical Examiner

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐Yes 2☒No	Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA	Other: 4☐Nursing Home 5☒Residence 8☐Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 8☐Could not be determined		M	1☐Yes 2☐No	
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶	D53968	March 30, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Ellie Goldbloom, MD 21 Crossroads Drive #400 Owings Mills, MD 21117

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
APR 03 2001	Pendra B Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

AMEND ITEM 7 per fh G794 040301 SS

Certificate of Death

Reg. No. 2001 10138

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): ELLA QUARLES

2. Date of Death: Month 3 Day 25 Year 2001

3. Time of Death: 0018

4a. Facility Name (If not institution, give street and number): BON SECOURS HOSPITAL

4b. City, Town, or Location of Death: BALTIMORE

4c. County of Death: —

Funeral Director

5. Social Security Number: 417-52-6804

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 67 ~~68~~ Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): 12 30 1933

9. Birthplace (State or Foreign Country): A.L.

Usual Residence of Decedent

10a. State: MD

10b. County: NA

10c. City, Town or Location: BALTIMORE

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 1844 WEST SARATOGA STREET

10f. Zip Code: 21223

10g. Citizen of What Country? U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: BLACK

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 10th GRADE; College (1-4or 5+): NA

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): DOMESTIC WORKER

16b. Kind of Business/Industry: PRIVATE HOME

17. Father's Name (First, Middle, Last): HARRY WATTS

18. Mother's Name (First, Middle, Maiden Surname): O-DOSCA DURANT.

19a. Informant's Name/Relationship (Type, Print): WILLIE HILL - DAUGHTER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 7423 SHIRLEY ROAD, BALTIMORE MD 21207

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): ARBUTUS MEMORIAL PARK

Date: 3/29/01

20c. Location - City or Town, State: ARBUTUS, MD.

21. Signature of Funeral Service Licensee: Lola March

22. Name and Address of Facility: MARCH F/H WEST 4300 WABASH AVE. BALTIMORE, MD 21215

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Acute Myocardial Infarction — 25 minutes

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
b.

Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☐ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☒ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Salvatore Raiti MD

29c. License number: D 12753

29d. Date signed (Month, Day, Year): 3/25/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): SALVATORE RAITI BON SECOURS HOSPITAL, BALTIMORE

State Registrar

31. Date filed (Month, Day, Year): APR 0 3 2001

32. Registrar's Signature: Geneva G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

CK

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 10139

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Cornelius Michael Ryan
2. Date of Death (Month, Day, Year): March 27, 2001
3. Time of Death: 0500
4a. Facility Name (If not institution, give street and number): 3701 Gough Street
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 214-44-2506
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 55 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 08-24-1945
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: MD
10b. County: Baltimore
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10a. Street and Number: 3701 Gough Street
10f. Zip Code: 21224
10g. Citizen of What Country?: United States

11. Marital Status: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Yeer or Dates: unk
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indien, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Mover
16b. Kind of Business/Industry: Moving and Storage

17. Father's Name (First, Middle, Last): Cornelius Michael Ryan
18. Mother's Name (First, Middle, Maiden Surname): Magdalena Mary Loeffler

19a. Informant's Name/Relationship (Type, Print): Mary Brigandi / Sister
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3701 Gough St. Baltimore, MD 21224

20a. Method of Disposition: 1 [ ] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [X] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Anatomic Gift Fnd
Date: 3/27/01
20c. Location - City or Town, Stete: Laurel, MD

21. Signature of Funeral Service Licensee: ▶ S J O
22. Name and Address of Facility: Anatomic Gift Foundation 13948 Baltimore Ave. Laurel, MD 20707

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Squamous cell Carcinoma of lung with metastasis

Due to (or as e consequence of):
b. Smoking.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Due to (or as a consequenca of):
c. —

Due to (or as a consequence of):
d. —

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
Pharyngeal Carcinoma.
COPD.
Alcohol Abuse.

23b. Did tobacco use contribute to the cause of death? 1 [X] Yes 2 [ ] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one)
Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA
Other: 4 [ ] Nursing Home 5 [X] Residenca 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year): N/A
28b. Time of Injury: M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, offica building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signeture and title of certifier: ▶ A. Hemani M.D.
29c. License number: D0041514
29d. Date signed (Month, Day, Year): 4/2/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Dinoo G. HEMANI M.D. 10. N. Greene St. Baltimore, MD 21201

State Registrar

31. Date filed (Month, Day, Year): APR 03 2001
32. Registrar's Signature: ▶ B Sparks

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 10140

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): May Richardson
2. Date of Death (Month, Day, Year): March 27, 2001
3. Time of Death: 6:00am M
4a. Facility Name (If not institution, give street and number): 2003 Ford Lane
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: n/a

Funeral Director

5. Social Security Number: 219-18-2112
6. Sex: 1☐M 2☒F
7. Age (In yrs. last birthday): 87 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 5/5/1913
9. Birthplace (State or Foreign Country): Maryland

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: MD
10b. County: n/a
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1☒Yes 2☐No
10e. Street and Number: 2003 Ford Lane
10f. Zip Code: 21227
10g. Citizen of What Country? United States

11. Marital Status: 1☐Never Married 2☐Married 3☒Widowed 4☐Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐Yes 2☒No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No Specify:
14. Race - American Indian, Black, White, etc. Specify: white

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 8; College (1-4or 5+): 0
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker
18b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): William Ball
18. Mother's Name (First, Middle, Maiden Surname): Mary Hudson

19a. Informant's Name/Relationship (Type, Print): Clarence Richardson / Son
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 404 N Street, S.E. Glen Bernie, Maryland 21061

20a. Method of Disposition: 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Meadowridge Cemetery
Date: 5/30/2001
20c. Location - City or Town, State: Elkridge, Maryland

21. Signature of Funeral Service Licensee: Michele M Vetula
22. Name and Address of Facility: Hubbard Funeral Home, Inc. 4107 Wilkens Avenue, Baltimore, Maryland 21229

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Colon Cancer — 11 years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. Due to (or as a consequence of):

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐Yes 2☒No 9☐Unknown
23c. If yes, outcome of pregnancy: 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown
23d. Date of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

24a. Was an autopsy performed? 1☐Yes 2☒No
24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☒No

25. Was case referred to medical examiner? 1☐Yes 2☒No

26. Place of Death (Check only one): Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☒Residence 8☐Other (Specify)

27. Manner of Death: 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐Yes 2☐No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification; To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☒Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end piece, end due to the cause(s) and manner stated.

29b. Signature and title of certifier: Edward Whitt MD
29c. License number: D23365
29d. Date signed (Month, Day, Year): 3/28/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): 405 Frederick Rd. Suite 202 Baltimore, MD 21228

State Registrar

31. Date filed (Month, Day, Year): APR 03 2001
32. Registrar's Signature: Geneva G Sparks

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 10141

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month	Day	Year	3. Time of Death
Lois Belle Riley	March	24	2001	8:30P M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Caton Manor	Baltimore	n/a

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
214-24-9225	1☐M 2☒F	87 Yrs.			Oct. 31, 1913	Virginia

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	n/a	Baltimore	1☒Yes 2☐No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
2540 Wilkens Avenue	21223	United States

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐Never Married 2☐Married 3☒Widowed 4☐Divorced	1☐Yes 2☒No If Yes, Give Year or Dates:	1☐Yes 2☒No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
11	0	Laundry Attendant	Hospital

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
George Menefee	Nannie Coward

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Brenda Riley - granddaughter-in-law	2540 Wilkens Avenue, Baltimore, Maryland 21223

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	Crestlawn Cemetery	3/28/01	Marriottsville, MD

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ Ann Y. Zink	Hubbard Funeral Home, Inc. 4107 Wilkens Avenue Baltimore, Maryland 21229

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	e. Aspiration Pneumonia	10 days
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of): Cerebrovascular Accident	10 days
	c. Due to (or as a consequence of):	
	d. Due to (or as a consequence of):	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month / Day / Year
1☐Yes 2☒No 9☐Unknown	1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Chronic Atrial Fibrillation

Dementia

23e. Did tobacco use contribute to the cause of death?	24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐Yes 2☒No 3☐Probably 4☐Unknown	1☐Yes 2☒No	1☐Yes 2☒No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐Yes 2☒No	Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA	Other: 4☒Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined		M	1☐Yes 2☐No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one) 1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end manner as stated. 2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ Geetha Raja MD	D27541	March 26, 2001

30. Name end address of person who completed causa of death (Item 23a) (Type, Print)

Geetha Raja, 4367 Hollins Ferry Road, Baltimore, Maryland 21227

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
APR 0 3 2001	▶ Geneva G Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 10142

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Nihla G. Rohrback
2. Data of Death (Month, Day, Year): March 31, 2001
3. Time of Death: 1:40p M
4a. Facility Name (If not institution, give street and number): Greater Baltimore Medical Center
4b. City, Town, or Location of Death: Towson
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 219-30-3119
6. Sex: 1☐M 2☒F XX
7. Age (In yrs. last birthday): 65 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Data of Birth (Month, Day, Year): Jan 1, 1936
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: N/A
10c. City, Town or Location: Baltimore
10d. Inside City Limits: XX 1☒Yes 2☐No
10e. Street and Number: 849 Powers Street
10f. Zip Code: 21211
10g. Citizen of What Country?: USA

11. Marital Status: 1☐Never Married XX☒Married 3☐Widowed 4☐Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐Yes 2☒No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puarto Rican, atc.) 1☐Yas 2☒ No Specify:
14. Race - Amaricen Indian, Bleck, Whita, atc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4or 5+):
16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT use ratired): Homemaker
16b. Kind of Businass/Industry: Own Home

17. Fether's Name (First, Middle, Last): Erman Smith
18. Mother's Nama (First, Middla, Meiden Surneme): Myrlie Mc Cleary

19a. Informant's Name/Relationship (Type, Print): Melvin F. Rohrback Husband
19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda): 849 Powers STreet, Baltimore, Maryland 21211

20a. Method of Disposition: 1☒Burial 2☐Cremation 3☐Removal from Stata 4☐Donation 5☐Othar (Specify)
20b. Place of Disposition (Name of cematary, cremetory or other place): Locust Valley Bible Church Cemetery
Data: 04/04/2001
20c. Location - City or Town, Stata: Middletown, MD

21. Signature of Funeral Service Licensee: Harry H. Capute
22. Nama and Address of Facility: Burgee-Henss-Seitz Funeral Home, 21211 3631 Falls Road, Baltimore, Maryland

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter tha mode of dying, such es cardiac or respiratory arrast, shock, or heart failure. List only one cause on each line.

Approximata Intarval Batween Onsat and Daath

Immediate Cause (Final disease or condition resulting in death):
a. PERFORATED VISCUS — 2 DAYS

Dua to (or as a consequence of):
b. MESENTERIC ISCHEMIA — 1 WEEK

Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Dua to (or as a consequence of):
c.

Dua to (or as a consequence of):
d.

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐Yas 2☑No 9☐Unknown
23c. If yes, outcoma of pregnancy: 1☐Liva birth 2☐Fatal death 3☐Ectopic pregnancy 4☐Pregnant at tima of death 5☐Othar (specify) 9☐Unknown
23d. Dete of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not rasulting in tha underlying cause given in Part I.
DIABETES MELLITUS

23e. Did tobacco usa contributa to tha causa of daath? 1☑Yas 2☐No 3☐Probably 4☐Unknown

24a. Was an autopsy performed? 1☐Yas 2☑No
24b. Wara autopsy findings availabla prior to completion of ceuse of daath? 1☐Yes 2☐No

Medical Certification: To Be Completed by Physician/Medical Examiner

25. Was cese refarred to medical examiner? 1☐Yas 2☑No

28. Place of Death (Check only one): Hospital: 1☑Inpatient 2☐ER/Outpatient 3☐DOA Othar: 4☐Nursing Home 5☐Rasidance 6☐Othar (Specify)

27. Manner of Death: 1☑Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

28a. Data of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐Yas 2☐No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, atc. (Specify)
28f. Location (Straat and Number or Rural Routa Numbar, City or Town, State)

29a. Certifier (Check only one): 1☑ **Certifying Physician:** To tha best of my knowledge, death occurred at the time, date and place, and dua to tha causa(s) and manner as stated.
2☐ **Medical Examiner:** On tha basis of examination and/or investigation, in my opinion, death occurred at tha time, data and place, and dua to the cause(s) and mannar stated.

29b. Signature and title of certifier:
29c. License number: D31189
29d. Data signed (Month, Day, Year): 4/1/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): MICHAEL J. MININSOHN, MD 8813 WALTHAM WOODS Rd, BALTIMORE, MD

State Registrar

31. Date filed (Month, Day, Year): APR 03 2001
32. Registrar's Signature: Geneva G Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Rohrback, Nihla

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23e or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No: 2001 10143

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): LILLIAN CATHERINE RIES

2. Date of Death (Month, Day, Year): APRIL 2, 2001

3. Time of Death: 7:00 AM

4a. Facility Name (If not institution, give street and number): 213 WILSON BOULEVARD

4b. City, Town, or Location of Death: GLEN BURNIE

4c. County of Death: ANNE ARUNDEL

Funeral Director

5. Social Security Number: 216-09-0565

8. Sex: 1☐M 2☒F

7. Age (In yrs. last birthday): 85 Yrs.

If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): APRIL 15, 1915

9. Birthplace (State or Foreign Country): MARYLAND

Usual Residence of Decedent

10a. State: MARYLAND

10b. County: ANNE ARUNDEL

10c. City, Town or Location: GLEN BURNIE

10d. Inside City Limits: 1☐Yes 2☒No

10e. Street and Number: 213 WILSON BOULEV ARD

10f. Zip Code: 21061

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐Never Married 2☒Married 3☐Widowed 4☐Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐Yes 2☒No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐Yes 2☒No Specify:

14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 8; College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): HOMEMAKER

16b. Kind of Business/Industry: OWN HOME

17. Father's Name (First, Middle, Last): JAMES McGUIRE

18. Mother's Name (First, Middle, Maiden Surname): LILLIAN CATHERINE (UNKNOWN)

19a. Informant's Name/Relationship (Type, Print): MR. JOHN F. RIES (HUSBAND)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 213 WILSON BOULEVARD, GLEN BURNIE, MD. 21061

20a. Method of Disposition: ☒1 Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): MARYLAND VETERANS CEMETERY Date: 4/5/2001

20c. Location - City or Town, State: CROWNSVILLE, MD.

21. Signature of Funeral Service Licensee: [signature] M01220

22. Name and Address of Facility: SINGLETON FUNERAL HOME, P.A., 1 SECOND AVENUE, S.W., GLEN BURNIE, MD. 21061

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Colon Cancer — 7 years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. Due to (or as a consequence of):

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐Yes 2☒No 9☐Unknown

23c. If yes, outcome of pregnancy: 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown

23d. Date of delivery: Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

24a. Was an autopsy performed? 1☐Yes 2☒No

24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☒No

25. Was case referred to medical examiner? 1☐Yes 2☒No

28. Place of Death (Check only one): Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA; Other: 4☐Nursing Home 5☒Residence 6☐Other (Specify)

27. Manner of Death: 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐Yes 2☒No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature]

29c. License number: D18508

29d. Date signed (Month, Day, Year): 04-02-01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Charles J. Wilms 1600 S. Crain Highway Glen Burnie Md. 21061

State Registrar

31. Date filed (Month, Day, Year): APR 0 3 2001

32. Registrar's Signature: [signature] G Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification; To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 10144

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): HELEN SINGLETON
2. Date of Death: Month APRIL Day 2 Year 2001
3. Time of Death: 10:02 AM
4a. Facility Name (If not institution, give street and number): 5430 PARK HEIGHTS AVENUE #316
4b. City, Town, or Location of Death: BALTIMORE
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 218-22-2750
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 72 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 01-03-1928
9. Birthplace (State or Foreign Country): MD

Usual Residence of Decedent

10a. State: MD
10b. County: N/A
10c. City, Town or Location: BALTIMORE
10d. Inside City Limits: 1☑ Yes 2☐ No
10e. Street and Number: 5430 PARK HEIGHTS AVE. # 316
10f. Zip Code: 21215
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☐ Widowed 4☑ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☑ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☑ No Specify:
14. Race - American Indian, Black, White, etc. Specify: BLACK

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12TH GRADE | College (1-4or 5+): N/A
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): MAILROOM CLERK
16b. Kind of Business/Industry: SOCIAL SECURITY

17. Father's Name (First, Middle, Last): THOMAS JOHNSON
18. Mother's Name (First, Middle, Maiden Surname): ANNIE WILLIAMS

19a. Informant's Name/Relationship (Type, Print): JANET PERKINS / DAUGHTER
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 660 LUCKY LEAF CIRCLE, CATONSVILLE, MD 21228

20a. Method of Disposition: 1☑ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetary, crematory or other place): DULANEY VALLEY
Date: 04.06.01
20c. Location - City or Town, State: TIMONIUM MD

21. Signature of Funeral Service Licensee: ▶ Vaughn C
22. Name and Address of Facility: VAUGHN C. GREENE FUNERAL SERVICE 5151 BALTO. NATL PIKE, BALTO. MD. 21229

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death):
a. Myocardial Infarction
Due to (or as a consequence of):
b. Hypertension
Due to (or as a consequence of):
c. Diabetes Mellitus
Due to (or as a consequence of):
d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
STROKE

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☒ Residence 8☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28b. Time of Injury: M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Date of Injury (Month, Day Year)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: ▶ Sankaran M.D
29c. License number: D21649
29d. Date signed (Month, Day, Year): April 2 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): SAMBANDAM BASKARAN . 3455 WILKENS AVE. BALTIMORE MD 21229

State Registrar

31. Date filed (Month, Day, Year): APR 03 2001
32. Registrar's Signature: ▶ Irene B. Sparks

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 16 Rev 6/95

ORIGINAL

Amend Items Pt I, Pt II,per DrG794,04/03/01dhb

2001 10145

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): DONALD SMITH				2. DATE OF DEATH (Month, Day, Year): 03 26 01	3. TIME OF DEATH: 1215 M
4. SOCIAL SECURITY NUMBER: 215-70-1772	5. SEX: 1 ☐ M 2 ☐ F XX	6. AGE (In yrs. last birthday): 41 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): 10-07-59	8. BIRTHPLACE (State or Foreign Country): MD
9a. FACILITY NAME (If not institution, give street and number): Eastern Correctional Institution		9b. CITY, TOWN OR LOCATION OF DEATH: Westover		9c. COUNTY OF DEATH: Somerset	
RESIDENCE OF DECEDENT					
10a. STATE: MD	10b. COUNTY: NA	10c. CITY, TOWN OR LOCATION: Baltimore		10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☐ NO XX	
10e. STREET AND NUMBER: 310 East 27th Street		10f. ZIP CODE: 21218		10g. CITIZEN OF WHAT COUNTRY?: USA	
11. MARITAL STATUS: 1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☐ NO XX Specify:		14. RACE — American Indian, Black, White, etc. Specify: Black	
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 9th Grade; College (1-4 or 5+): NA		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): S.P.C.A.		16b. KIND OF BUSINESS/INDUSTRY: City of Baltimore	
17. FATHER'S NAME (First, Middle, Last): Johnny Smith		18. MOTHER'S NAME (First, Middle, Maiden Surname): Velories Wallace			
19a. INFORMANT'S NAME (Type/Print): Baha Wali		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 8215 Consett Court Severn, Maryland 21144			
20a. METHOD OF DISPOSITION: ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Voshell Mem. Gardens	DATE: 04-02-01	20c. LOCATION — City or Town, State: Dundalk, MD	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Jean C Curtz		22. NAME AND ADDRESS OF FACILITY: Baltimore, Maryland WM.C. March FH 1101 E. North Avenue			

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. METASTATIC SQUAMOUS CARCINOMA OF THE LUNG	3 MONTHS
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. NONE	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c. NONE	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

NONE

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES ☐ NO ☐ UNCERTAIN ☒

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☒ NO		
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☒ YES 2 ☐ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify) PRISON INFIRMARY		
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 8 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
	28d. DESCRIBE HOW INJURY OCCURED		
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)

1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
	D0050826	▶ 3-26-01

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): LAZAAIC A. ENIOLA 30420 PENSELL'S NECK RD WESTOVER, MD 21890

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
APR 03 2001	Geneva G Sparks

DHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 6876, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 10146

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): MELVA L SAGNER

2. Date of Death: Month March Day 31 Year 2001

3. Time of Death: 630pm

4a. Facility Name (If not institution, give street and number): Franklin Square Hospital Center

4b. City, Town, or Location of Death: Rosedale

4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 214-16-9900

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 78 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): July 14, 1922

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: MD

10b. County: Baltimore

10c. City, Town or Location: Middle River

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 3500 Honeysuckle Lane

10f. Zip Code: 21220

10g. Citizen of What Country? USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedant of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 8th | College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Sales Clerk

16b. Kind of Business/Industry: Camera Shop

17. Father's Name (First, Middle, Last): William Doxen

18. Mother's Name (First, Middle, Maiden Surname): Ethel Jackson

19a. Informant's Name/Relationship (Type, Print): John Sagner Jr./son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3500 Honeysuckle LAne Baltimore MD 21220

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetary, crematory or other place): Lakeview Cemetery Date: 4/4/01

20c. Location - City or Town, State: Baltimore MD

21. Signature of Funeral Service Licensee: ▶ R. Terry Connelly

22. Name and Address of Facility: Connelly Funeral Home of Essex, 300 MAce Ave. Baltimore MD 21221

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. | Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Aspiration Pneumonia

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:

b. Sepsis

Due to (or as a consequence of):

c. Cerebravascular Accident

Due to (or as a consequence of):

d. Colon Cancer

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Diabetes Mellitus

23b. Did tobacco use contribute to the cause of death? 1☒ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Dan Tran MD

29c. License number: D0056972

29d. Date signed (Month, Day, Year): March 31 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Dr Dan Tran 9000 Franklin Square Drive Baltimore Maryland 21237

State Registrar

31. Date filed (Month, Day, Year): APR 0 3 2001

32. Registrar's Signature: ▶ Geneva G Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Sagner, Melva
Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

Amend Item 23 Pt 1,G794,04/02/01dhb
Per Dr Pt II

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No: 2001 10147

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Louis Strauss

2. Date of Death — Month: March; Day: 24; Year: 2001

3. Time of Death: 0220

4a. Facility Name *(If not institution, give street and number)*: Sinai Hospital of Baltimore

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: N/A

Funeral Director

5. Social Security Number: 218-14-0403

6. Sex: 1 [X] M 2 [ ] F

7. Age *(In yrs. last birthday)*: 77 Yrs.

If Under 1 Year — Months: ; Days:

If Under 24 Hrs. — Hours: ; Min.:

8. Date of Birth *(Month, Day, Year)*: AUG. 6, 1923

9. Birthplace *(State or Foreign Country)*: MD

Usual Residence of Decedent

10a. State: MD

10b. County: HOWARD

10c. City, Town or Location: ELLICOTT CITY

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 3141 WHEATON WAY #D

10f. Zip Code: 21043

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No — If Yes, Give Year or Dates: WWII

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 [ ] Yes [X] No — Specify:

14. Race - American Indian, Black, White, etc. — Specify: WHITE

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12; College (1-4 or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: FIREMAN

16b. Kind of Business/Industry: CONRAIL

17. Father's Name *(First, Middle, Last)*: MAX STRAUSS

18. Mother's Name *(First, Middle, Maiden Surname)*: KATIE ROSENTHAL

19a. Informant's Name/Relationship *(Type, Print)*: SHIRLEY STRAUSS / WIFE

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 3141 WHEATON WAY #D - ELLICOTT CITY, MD 21043

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: ACHIM AHAVAS SHALOM AGUDIS — Date: 3/26/01

20c. Location - City or Town, State: ROSEDALE, MD

21. Signature of Funeral Service Licensee: Jay Allan Lewis

22. Name and Address of Facility: SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): e. ~~Multiorgan System Failure~~ Ischemic bowel — 1 day ~~10 days~~

Due to (or as a consequence of): Severe Coronary Artery Disease — years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

~~Seizure~~

~~Coronary Artery Bypass Surgery~~

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [X] Yes 2 [ ] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death *(Check only one)*: Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other *(Specify)*

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury *(Month, Day, Year)*:

28b. Time of Injury:

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred:

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*:

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*:

29a. Certifier *(Check only one)*: 1 [X] **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Marc Chodos MD

29c. License number: [illegible] 000

29d. Date signed *(Month, Day, Year)*: March 24, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Marc Chodos / Sinai Hospital of Baltimore / Baltimore MD

State Registrar

31. Date filed *(Month, Day, Year)*: APR 02 2001

32. Registrar's Signature: [illegible] Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar AMND ITM#10D PER F.H. G794 4-3-01 JAB

Certificate of Death

Reg. No. 2001 10148

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Mary Elizabeth Snyder

2. Data of Death Month: April Day: 2 Year: 2001

3. Time of Death: 6:15 AM

4a. Facility Name (If not institution, give street and number): Sinai Hospital of Baltimore

4b. City, Town, or Location of Death: Baltimore City

4c. County of Death:

Funeral Director

5. Social Security Number: 214-44-2862

6. Sex: 1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday): 91 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Data of Birth (Month, Day, Yaar): Feb. 25 1910

9. Birthplace (State or Foreign Country): North Carolina

Usual Residence of Decedent

10a. State: MD

10b. County: n/a

10c. City, Town or Location: Baltimore

10d. Insida City Limits: 1 ☒ Yas 2 ☐ No

10e. Street and Number: 2211 W. Rogers Ave.

10f. Zip Coda: 21209

10g. Citizan of What Country?: USA

11. Maritial Status: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Evar in U.S. Armed Forcas? 1 ☐ Yas 2 ☒ No If Yes, Giva Yaar or Dates:

13. Was Dacedant of Hispanic Origin? (Specify Yas or No- tf Yes, specify Cuban, Maxican, Puarto Rican, atc.) 1 ☐ Yas 2 ☒ No Specify:

14. Rece - Americen Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highast grade completed)

Elementary/Secondary (0-12): 12

College (1-4or 5+): 4

16a. Decedent's Usual Occupation (Giva kind of work dona during most of working life. DO NOT use ratired): Homemaker

16b. Kind of Businass/Industry: Own Home

17. Father's Name (First, Middle, Last): Thomas Settles Davis

18. Mother's Name (First, Middla, Maiden Sumame): Roberta Ellen Graham

19a. Informant's Name/Ralationship (Type, Print): John E. Snyder/Son

19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code): 18 Wendslow Rd., Lutherville, MD 21093

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from Stata 4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Nama of cemetery, crematory or othar place): Dulaney Valley Memorial Gardens

Data: 4/5/01

20c. Location - City or Town, Stata: Timonium, MD 21093

21. Signature of Funaral Service Licensee: ▶ Bryan W. Clary

22. Name and Address of Facility: Lemmon Funeral Home 10 W. Padonia Rd., Timonium, MD 21093

Physician /Medical Examiner

23a. Part I. Enter the disease, or complicetions that caused the death. Do not antar tha moda of dying, such as cardiac or respiratory errast, shock, or heart failura. List only ona cause on each line.

Approximata Intarval Batwaan Onsat and Death: 1 week

Immediata Cause (Final disease or condition resulting in death)

a. Pneumonia

Dua to (or as a consequence of):

Sequentially list conditions, if any, leading to immediete cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Dua to (or as a consequenca of):

c. Dua to (or as a consequence of):

d.

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☒ No 9 ☐ Unknown

23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal deeth 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at tima of death 5 ☐ Othar (specify) 9 ☐ Unknown

23d. Data of dalivary Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in tha underlying causa givan in Part I.

urinary tract infection

dementia

23a. Did tobecco usa contribute to tha causa of death? 1 ☐ Yes 2 ☒ No 3 ☐ Probebly 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yas 2 ☒ No

24b. Were autopsy findings availabla prior to completion of cause of daath? 1 ☐ Yas 2 ☐ No

25. Was case referred to medical axaminer? 1 ☐ Yes 2 ☒ No

26. Placa of Daath (Check only ona)

Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other: 4 ☐ Nursing Homa 5 ☐ Rasidanca 6 ☐ Othar (Specify)

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be datarmined

28a. Data of Injury (Month, Day Year)

28b. Tima of Injury M

28c. Injury at Work? 1 ☐ Yas 2 ☐ No

28d. Dascribe how injury occurred

28e. Place of Injury - At home, farm, streat, factory, office building, etc. (Specify)

28f. Location (Street and Numbar or Rural Routa Numbar, City or Town, Stata)

29a. Certifier (Check only one) 1 ☒ **Certifying Physician:** To tha best of my knowledga, daath occurred at tha tima, data and placa, and due to tha cause(s) and mannar as stated. 2 ☐ **Medical Examiner:** On the basis of axamination and/or investigation, in my opinion, daath occurred at the time, date and place, and dua to tha causa(s) and mannar stated.

29b. Signature and title of certifier: ▶ Malka Blass, MD

29c. License number: RES-000

29d. Data signed (Month, Day, Year): April 2, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Malka Blass Sinai Hospital of Baltimore 2401 West Belvedere Ave

State Registrar

31. Data filed (Month, Day, Year): APR 03 2001

32. Registrar's Signature: Geneva B Sparks

DHMH 17 Rev 1/2001

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked othar than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification; To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

pt known as Mary Snyder

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 10149

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): John Wyse Shelley
2. Date of Death (Month, Day, Year): 03-31-01
3. Time of Death: 5:10pm
4a. Facility Name (If not institution, give street and number): Maryland Masonic Homes
4b. City, Town, or Location of Death: Cockeysville
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 216-03-0210
6. Sex: 1☒ M 2☐ F
7. Age (In yrs. last birthday): 95 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): June 11, 1905
9. Birthplace (State or Foreign Country): MD

Usual Residence of Decedent

10a. State: MD
10b. County: Baltimore
10c. City, Town or Location: Cockeysville
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 300 International Cir.
10f. Zip Code: 21030
10g. Citizen of What Country: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 8 | College (1-4or 5+): N/A
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Engineer
16b. Kind of Business/Industry: Railroad

17. Father's Name (First, Middle, Last): George K. Shelley
18. Mother's Name (First, Middle, Maiden Surname): Mary Shipley

19a. Informant's Name/Relationship (Type, Print): Richard H. Shelley/SON
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1115 Sturbridge Road Fallston, MD 21047

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Moreland Memorial Park Cemetery
Date: April 4 2001
20c. Location - City or Town, State: Parkville, MD

21. Signature of Funeral Service Licensee: Michael J. Flagle
22. Name and Address of Facility: Lemmon Funeral Home of Dulaney Valley, Inc. 10 W. Padonia Road Timonium, MD 21093

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. (Approximate Interval Between Onset and Death)

Immediate Cause (Final disease or condition resulting in death): a. Dementia - End Stage.

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: h/o Stroke, h/o tube feeding, h/o CHF

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: R. Liberto, MD.
29c. License number: D21464
29d. Date signed (Month, Day, Year): 4/2/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): ROBERT LIBERTO, MD. 3508 BANK ST BALTO., MD 21224

State Registrar

31. Date filed (Month, Day, Year): APR 03 2001
32. Registrar's Signature: Brenda B Sparks

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. **To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar AMEND ITEM 7 per fh G794 040301 SS

Certificate of Death

Reg. No. 2001 10150

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23e or 28a-i show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Physician /Medical Examiner

Funeral Director

To Be Completed by Funeral Director

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
Lilavati J. Sheth	March 31, 2001	5:20 AM M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Shady Grove Adventist Health Care	Gaithersburg	Montgomery

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year Months / Days	If Under 24 Hrs. Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
217-08-2515	1☐M 2☒F	~~77~~ 76 Yrs.			04/17/1924	India

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	Montgomery	Gaithersburg	1☐Yes 2☒No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
14100 Silent Wood Way	20878	India

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐Never Married 2☒Married 3☐Widowed 4☐Divorced	1☐Yes 2☒No If Yes, Give Year or Dates:	1☐Yes 2☒No Specify:	Specify: Hindu

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12	0	Housewife	

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Sunderlal U. Marjadi	Nirmalateu S. Marjadi

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Jayantilal J. Sheth-husband	14100 Silent Wood Way, Gaithersburg, MD., 20878

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☐Burial 2☒Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	Balt./Wash. Crematory	04/01/2001	Laurel, Maryland

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ [signature]	Fleck Funeral Home 7601 Sandy Spring Road, Laurel, MD., 20707

Physician /Medical Examiner

Medical Certification; To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory errest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	e. Pneumonia	WK.
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or es e consequence ol): b. Cerebrovascular accident	YR.
	Due to (or es a consequence of): c. Insulin Dependent Diabetes	Yrs.
	Due to (or as a consequence ol): d. Renal failure	Yrs.

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome ol pregnancy	23d. Date ol delivery Month Day Year
1☐Yes 2☒No 9☐Unknown	1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) _____ 9☐Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?	24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐Yes 2☒No 3☐Probably 4☐Unknown	1☐Yes 2☒No	1☐Yes 2☒No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐Yes 2☒No	Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA	Other: 4☒Nursing Home 5☐Residence 8☐Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined		M	1☐Yes 2☐No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner es steted. 2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) end manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Yeer)
▶ [signature] MD	D35792	MARCH, 31ST, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
SWAROOP G RAO; 50, W. Edmonston Dr, Rockville

State Registrar

31. Date filed (Month, Dey, Year)	32. Registrar's Signature
APR 0 3 2001	▶ [signature]

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No 2001 10151

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month / Day / Year	3. Time of Death
Anna Bertha Staskowiak	March 31 2001	7:50 a.M.

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Franklin Woods	Baltimore	Baltimore

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
212-03-2120	1☐M 2☒F	82 Yrs.			March 6, 1919	Maryland

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Baltimore	Baltimore	1☐Yes 2☒No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
6840 Boston Avenue	21222	United States

11. Marital Status	12. Wes Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Rece - American Indian, Black, White, etc.
1☐Never Married 2☐Married 3☒Widowed 4☐Divorced	1☐Yes 2☒No If Yes, Give Year or Dates:	1☐Yes 2☒No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
9 years		Homemaker	Own Home

17. Father's Name (First, Middle, Last)	18. Mother's Neme (First, Middle, Maiden Surname)
Frederick Reitz	Katherine Stachlinski

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code)
Gerald Staskowiak (Son)	2731 Moorgate Road Dundalk, Maryland 21222

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	St. Stanislaus Cemetery	4/3/01	Baltimore, Maryland

21. Signeture of Funeral Service Licensee	22. Name and Address of Facility
▶ Stephanie Massey	Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Avenue Dundalk, Maryland 21222

Physician /Medical Examiner

Medical Certification; To Be Completed by Physician/Medical Examiner

23a. Part1. Enter the disease, or complications thet caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line.

		Approximete Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Congestive Heart failure	3 Month
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury thet initieted events resulting in death) Last	b. Due to (or as e consequence of):	
	c. Due to (or as a consequence of):	
	d. Due to (or as a consequence of):	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Dete of delivery Month / Dey / Year
1☐Yes 2☒No 9☐Unknown	1☐Live birth 2☐Fetel death 3☐Ectopic pregnency 4☐Pregnant at time of deeth 5☐Other (specify) _____ 9☐Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobecco use contribute to the cause of death? 1☐Yes 2☒No 3☐Probebly 4☐Unknown

24e. Was en autopsy performed?	24b. Were eutopsy findings available prior to completion of cause of death?
1☐Yes 2☒No	1☐Yes 2☐No

25. Wes case referred to medical examiner?	28. Place of Death (Check only one)
1☐Yes 2☒No	Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☒Nursing Home 5☐Residence 8☐Other (Specify)

27. Mannes of Death	28a. Dete of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury et Work?	28d. Describe how injury occurred
1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined		M	1☐Yes 2☐No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1☒**Certifying Physician:** To the best of my knowledge, death occurred et the time, date end place, end due to the cause(s) end manner es stated. 2☐**Medical Examiner:** On the basis of exemination and/or investigation, in my opinion, deeth occurred at the time, date and place, end due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Dete signed (Month, Day, Year)
▶ M. Rahrama	D45425	4-2-01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M. Rahrama 8100 Harford Rd Balto MD 21234

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
APR 0 3 2001	▶ Jeanne D Starks

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

1- For State Registrar

Reg. No. 2001 10152

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Gerald J. Schisler, Sr.
2. Date of Death (Month, Day, Year): April 01 2001
3. Time of Death: 1:30 a M
4a. Facility Name (If not institution, give street and number): 607 Round Oak Ave.
4b. City, Town, or Location of Death: Towson
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 216-16-3603
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 80 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Jan. 21 1921
9. Birthplace (State or Foreign Country): Pennsylvania

Usual Residence of Decedent

10a. State: Md.
10b. County: Baltimore
10c. City, Town or Location: Towson
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 607 Round Oak Ave.
10f. Zip Code: 21204
10g. Citizen of What Country? USA

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: WWII
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Postal Worker
18b. Kind of Business/Industry: Post Office

17. Father's Name (First, Middle, Last): George Francis Schisler
18. Mother's Name (First, Middle, Maiden Surname): Agnes Irene Kane

19a. Informant's Name/Relationship (Type, Print): Mrs. Ethel Schisler/ Wife
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 607 Round Oak Ave. Towson, Md. 21204

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Dulaney Valley Mem. Gdns.
Date: 4-4-01
20c. Location - City or Town, State: Timonium, Md.

21. Signature of Funeral Service Licensee: ▶ Jeffrey J. Fair, Sr.
22. Name and Address of Facility: Ruck Towson Funeral Home, Inc. 1050 York Rd. Towson, Md. 21204

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. COPD
Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1 [ ] Yes 2 [ ] No 9 [ ] Unknown
23c. If yes, outcome of pregnancy: 1 [ ] Live birth 2 [ ] Fetal death 3 [ ] Ectopic pregnancy 4 [ ] Pregnant at time of death 5 [ ] Other (specify) 9 [ ] Unknown
23d. Date of delivery: Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Atherosclerotic CAD, PVD

23e. Did tobacco use contribute to the cause of death? 1 [X] Yes 2 [ ] No 3 [ ] Probably 4 [ ] Unknown
24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No
28. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; Other: 4 [ ] Nursing Home 5 [X] Residence 8 [ ] Other (Specify)
27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification; To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1 [X] Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: ▶ [signature]
29c. License number: D0032929
29d. Date signed (Month, Day, Year): 4/2/01
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Richard J. Antoato MD 7401 Osler Drive, Suite 201 Towson 21204

State Registrar

31. Date filed (Month, Day, Year): APR 0 3 2001
32. Registrar's Signature: [signature] G Sparks

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 10153

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Bernard A. Schmidt
2. Date of Death Month Day Year: April 01, 2001
3. Time of Death: 11:15AM
4a. Facility Name *(If not institution, give street and number)*: 8434 Cove Road
4b. City, Town, or Location of Death: Dundalk
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 219-32-9016
6. Sex: 1 [X] M 2 [ ] F
7. Age *(In yrs. last birthday)*: 62 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*:
9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Baltimore
10c. City, Town or Location: Dundalk
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 8434 Cove Road
10f. Zip Code: 21222
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [ ] Widowed 4 [X] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: Vietnam
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 — College (1-4or 5+): 4+
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Military Officer-Chief
16b. Kind of Business/Industry: Government

17. Father's Name *(First, Middle, Last)*: Charles Schmidt
18. Mother's Name *(First, Middle, Maiden Surname)*: Ruth Chepaitis

19a. Informent's Name/Relationship *(Type, Print)*: Janet Yodris - Niece
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 8434 Cove Road Baltimore, Maryland 21222

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*
20b. Place of Disposition *(Name of cemetary, crematory or other place)*: Greenmount Crematory
Date: 4-4-01
20c. Location - City or Town, State: Baltimore, Maryland

21. Signature of Funeral Service Licensee: Maria M. Zannino
22. Name and Address of Facility: Joseph N. Zannino Jr. Funeral Home 263 South Conkling Street Balto MD 21224

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Squamous Cell Carcinoma -Lung — 18 months

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying ceusa given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [X] Yes 2 [ ] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death *(Check only one)*: Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — Other: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other *(Specify)*

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, ferm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Mohamed Al-Ibrahim, M.D.
29c. License number: D15450
29d. Date signed *(Month, Day, Year)*: 4/2/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Mohamed Al-Ibrahim, M.D. 3900 Loch Raven Blvd, Baltimore, Maryland 21218

State Registrar

31. Date filed *(Month, Day, Year)*: APR 03 2001
32. Registrar's Signature: Geneva L. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 10154

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
Thelma Marie Thompson	April 2, 2001	10:26 p.m.

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Gilchrist Hospice Center	Towson	Baltimore

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
212-20-8665	1☐ M 2☒ F	76 Yrs.			Jan. 4, 1925	Ekl●, Md.

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Md.	Baltimore	Owings Mills	1☐ Yes 2☒ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
11425 Garrison Forest Road	21117	U.S.A.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced	1☐ Yes 2☒ No If Yes, Give Yaar or Dates:	1☐ Yes 2☒ No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work dona during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12		Homemaker	Homemaking

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Sumama)
George Orville Bull	Myrtle Pearle Hare

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21218
Sherri Ann Thompson - Daughter	3908 North Charles St. Unit 1103 Baltimore, Md.

20a. Method of Disposition	20b. Place of Disposition (Neme of cemetery, crematory or other piece)	Date	20c. Location - City or Town, State
1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)	Metro Crematory	April 3, 2001	Baltimore, Md.

21. Signature of Funeral Service Licensee: Justin R. Eckhardt

22. Nama and Address of Facility: Eckhardt Funeral Chapel, P.A. 11605 Reisterstown Rd. Owings Mills, Md. 21117

Physician /Medical Examiner

24a. Part I. Enter the disease, or complicetions that caused the death. Do not enter the mode of dying, such as cardiac or raspiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediete Ceuse (Finel disease or condition resulting in death)	a. Widely Metastatic breast ca.	3-3½ yrs
	Due to (or as a consequence of):	
Sequentielly list conditions, if any, teeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b.	
	Due to (or as a consequence of):	
	c.	
	Dua io (or as a consequence of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. **Did tobacco use contribute to the cause of death?** 1☒ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐ Yes 2☒ No	1☐ Yes 2☒ No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐ Yes 2☒ No	Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA	Other: 4☐ Nursing Home 5☐ Residence 6☒ Other (Specify) Hospice

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒ Netural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined		M	1☐ Yes 2☐ No	

28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and menner es stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and piece, and due to the cause(s) and manner stated.

29b. Signature and Title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
Ruth Kanter MD	D28594	4/2/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Ruth Kanter MD GBMC 6569 N Charles St. #210 Balto MD 21204

State Registrar

31. Date filed (Month, Dey, Year)	32. Registrar's Signature
APR 0 3 2001	Geneva G Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

4/2/01 Thompson, Thelma 10:26 pm

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 10155

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Hubbard Tann

2. Date of Death (Month, Day, Year): March 31 2001

3. Time of Death: 12 30 AM

4a. Facility Name (If not institution, give street and number): Mercy Medical Center

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: NA

Funeral Director

5. Social Security Number: 243-24-1921

6. Sex: 1☐M 2☐F XX

7. Age (In yrs. last birthday): 78 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): 03-14-23

9. Birthplace (State or Foreign Country): NC

Usual Residence of Decedent

10a. State: MD

10b. County: NA

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1☒Yes 2☐No

10e. Street and Number: 4113 LaSalle Avenue

10f. Zip Code: 21206

10g. Citizen of What Country? USA

11. Marital Status: 1☐Never Married 2☐Married XX☐Widowed 4☐Divorced

12. Was Decedent Ever in U.S. Armed Forces? X☐Yes 2☐No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No Specify:

14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 8th Grade

College (1-4or 5+): NA

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Maintenance

16b. Kind of Business/Industry: W.M.A.R. TV Channel #2 News

17. Father's Name (First, Middle, Last): Ernest Tann

18. Mother's Name (First, Middle, Maiden Surname): Daisy Barksdale

19a. Informent's Name/Relationship (Type, Print): Jane Tann

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21206: 4113 LaSalle Avenue Baltimore, Maryland

20a. Method of Disposition: 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Belle Family Cemetery

Date: 04-07-01

20c. Location - City or Town, State: Mt. Olive, NC

21. Signature of Funeral Service Licensee: Gladys Wane

22. Name and Address of Facility: Baltimore, Maryland 21202 WM.C.March FH 1101 E. North Avenue

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Cholangiocarcinoma.

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☐Unknown

24a. Was an autopsy performed? 1☐Yes 2☐No

24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☐No

25. Was case referred to medical examiner? 1☐Yes 2☐No

26. Place of Death (Check only one)

Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA

Other: 4☐Nursing Home 5☐Residence 8☐Other (Specify)

27. Manner of Death: 1☐Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐Yes 2☐No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☐**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: MD

29c. License number: D 40854

29d. Date signed (Month, Day, Year): April 2, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): DAVID RISEBERG 301 St Paul Pl BALTIMORE MD 21202

State Registrar

31. Date filed (Month, Day, Year): APR 0 3 2001

32. Registrar's Signature: Steven G Sparks

ORIGINAL

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If Item 27 is marked other than "natural", or Items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 10156

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Simonne M. Tochterman

2. Data of Death Month Day Year: March 31, 2001

3. Time of Death: 1:20 PM

4a. Facility Name (If not institution, give street and number): Keswick Multi-Care Center

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: N/A

Funeral Director

5. Social Security Number: 215-03-8029

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 86 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Data of Birth (Month, Day, Year): Sept 14, 1914

9. Birthplace (State or Foreign Country): France

Usual Residence of Decedent

10a. State: Maryland

10b. County: N/A

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 4401 Roland Avenue Apt. 110

10f. Zip Code: 21210

10g. Citizen of What Country? USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: white

15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12): unknown
College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker

16b. Kind of Business/Industry: In Own Home

17. Father's Name (First, Middle, Last): Gustave DeBouver

18. Mother's Name (First, Middle, Maiden Surname): Leonide

19a. Informant's Name/Relationship (Type, Print): Jack Tochterman (Son)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): P.O. Box 533 Middleburg, Virginia 20118

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Woodlawn Cemetery

Date: 4/5/01

20c. Location - City or Town, State: Woodlawn, Maryland

21. Signature of Funeral Service Licensee: James H Carpenter

22. Name and Address of Facility: Burgee-Henss-Seitz Funeral Home, Inc. 3631 Falls Road Baltimore, MD 21211

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): e. LUNG CANCER

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

CHRONIC OBSTRUCTIVE PULMONARY DISEASE

DEMENTIA

23b. Did tobacco use contribute to the cause of death? 1☑ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

28. Place of Death (Check only one)
Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA
Other: 4☑ Nursing Home 5☐ Residence 8☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: M Daly MD

29c. License number: D30433

29d. Date signed (Month, Day, Year): 4/2/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): M DALY GBMC 6701 N CHARLES ST BALTIMORE MD 21204

State Registrar

31. Date filed (Month, Day, Year): APR 03 2001

32. Registrar's Signature: B Sparks

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 10157

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Mary Louise Tucker

2. Date of Death (Month, Day, Year): MARCH 29, 2001

3. Time of Death: 01:05 AM

4a. Facility Name (If not institution, give street and number): St Agnes Hospital

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: N/A

Funeral Director

5. Social Security Number: 212 09 7478

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 83 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): April 15 1917

9. Birthplace (State or Foreign Country): Baltimore, Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Baltimore

10c. City, Town or Location: Baltimore County

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 1 Eugene Avenue

10f. Zip Code: 21221

10g. Citizen of What Country? USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 12

College (1-4or 5+): N/A

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Computer Operator

16b. Kind of Business/Industry: Meat Packing Industry

17. Father's Name (First, Middle, Last): Samuel Thomas Chenworth

18. Mother's Name (First, Middle, Maiden Surname): Agnes Rose Morlock

19a. Informant's Name/Relationship (Type, Print): E Stuart Tucker

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 6 Lagan Court Baltimore, Maryland 21236

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Gardens of Faith Cem.

Date: March 31 2001

20c. Location - City or Town, State: Baltimore, Maryland

21. Signature of Funeral Service Licensee: Heather Jessahn Chapnock

22. Name and Address of Facility: Lassahn Funeral Home, Inc 7401 Belair Road Baltimore, Maryland 21236

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. CARDIAC ARRHYTHMIA — 2 hours

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. CONGESTIVE HEART FAILURE

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one)

Hospital: 1☐ Inpatient 2☒ ER/Outpatient 3☐ DOA

Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: MD

29c. License number: D0051865

29d. Date signed (Month, Day, Year): March 29, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): CHARLES CURTS ST AGNES HOSPITAL

State Registrar

31. Date filed (Month, Day, Year): APR 03 2001

32. Registrar's Signature: Geneva G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

TUCKER, MARY

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 10158

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Stella J. Ulita

2. Date of Death: Month March Day 30, Year 2001

3. Time of Death: 6:30 A M

4a. Facility Name (If not institution, give street and number): Riverview Nursing Home

4b. City, Town, or Location of Death: Essex

4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 220-03-9269

6. Sex: 1☐M 2☒F

7. Age (In yrs. last birthday): 88 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Jan.1, 1913

9. Birthplace (State or Foreign Country): Romania

Usual Residence of Decedent

10a. State: Maryland

10b. County: Baltimore

10c. City, Town or Location: Essex

10d. Inside City Limits: 1☐Yes 2☒No

10e. Street and Number: 500 S. Marlyn Avenue Apt. 1A

10f. Zip Code: 21221

10g. Citizen of What Country? United States

11. Maritel Status: 1☐Never Married 2☐Married 3☐Widowed 4☒Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐Yes 2☒No If Yes, Give Year or Dates:

13. Wes Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 11

College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Telephone Operator

16b. Kind of Business/Industry: Telephone Company

17. Father's Name (First, Middle, Last): unk.

18. Mother's Name (First, Middle, Maiden Surname): unk.

19a. Informant's Name/Reletionship (Type, Print): Vernelle Bellon/ Personal Rep.

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 533 Riverside Drive Baltimore, MD 21221

20a. Method of Disposition: 1☐Burial 2☒Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)

20b. Place of Disposition (Name of cemetery, cremetory or other place): Chesapeake Crematory

Date: 04/02/01

20c. Location - City or Town, State: Beltsville, MD

21. Signature of Funeral Service Licensee: Lana C. Hardesty

22. Name and Address of Facility: CAFA Stephen D. Lohrmann P.A. 8717 Green Pastures Drive Baltimore, MD 21286

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Finel disease or condition resulting in death)

a. Athero Sclerotic Cardiovascula Disease — 2 yrs.

Due to (or as a consequence of):

b. Essential Hypertension — 10 yrs.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1☐Yes 2☒No 9☐Unknown

23c. If yes, outcome of pregnancy: 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant et time of death 5☐Other (specify) 9☐Unknown

23d. Date of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Diabetes Mellitus.

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☒Unknown

24a. Was an autopsy performed? 1☐Yes 2☒No

24b. Were autopsy findings available prior to completion of cause ot death? 1☐Yes 2☐No

25. Was case referred to medical examiner? 1☐Yes 2☒No

26. Place of Death (Check only one)

Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA

Other: 4☒Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death: 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

28a. Date of Injury (Month, Day Yeer)

28b. Time of Injury M

28c. Injury at Work? 1☐Yes 2☐No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to tha cause(s) and manner stated.

29b. Signature and title of certifier: ▶ [signature]

29c. License number: D30641

29d. Date signed (Month, Day, Yeer): April 01 2001

30. Name and address of person who completed cause ot death (Item 23a) (Type, Print): RAMESH SOBAPADY 8400 ERDMAN AVE. BALTIMORE MD 21213

State Registrar

31. Date filed (Month, Day, Year): APR 0 3 2001

32. Registrar's Signature: ▶ [signature]

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Medical Certification: To Be Completed by Physician/Medical Examiner

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DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

AMND ITM#20b PER F.H. G794 4-5-2001 JAB **Certificate of Death**

Reg. No. 2001 10159

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Patricia Y. Vergara
2. Data of Death Month Day Year: April 1, 2001
3. Time of Death: 2:00 AM
4a. Facility Name *(If not institution, give street and number)*: Stella Maris Hospice
4b. City, Town, or Location of Death: Timonium
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 214-50-1672
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 77 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Data of Birth *(Month, Day, Year)*: Nov. 22, 1923
9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Md.
10b. County: Baltimore
10c. City, Town or Location: Towson
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 910 Dunellen Drive
10f. Zip Code: 21286
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☒ Yes 2☐ No If Yes, Give Yeer or Detes: WWII
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Maxican, Puarto Rican, atc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, atc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elemantery/Secondary (0-12): — College (1-4or 5+): 4
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Nurse
16b. Kind of Business/Industry: Medical

17. Father's Name *(First, Middle, Last)*: William Joseph White
18. Mother's Name *(First, Middle, Maiden Surname)*: Edith Marie DesRochers

19a. Informant's Name/Relationship *(Type, Print)*: Mr. Rollo C. Baker, III/Per. Rep.
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 932 Dunellen Drive Towson, Maryland 21286

20a. Method of Disposition: 1☐ Burial 2☒ Cremetion 3☐ Ramovei from Stete 4☐ Donation 5☐ Othar *(Specify)*
20b. Place of Disposition *(Name of cemetary, cramatory or othar place)*: Hilltop Service Corp. Date: 4/3/01 ~~3/2/01~~
20c. Location - City or Town, State: Towson, Maryland

21. Signature of Funeral Service Licansee: Michael J Ruck
22. Name and Address of Facility: Ruck Towson Funeral Home, Inc. 1050 York Road Towson, Maryland 21204

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications thet caused the daath. Do not antar tha moda of dying, such as cardiac or raspiratory arrest, shock, or haert faitura. List only ona causa on aach line. — Approximate Intarval Between Onset and Death

Immediate Cause (Final disaasa or condition resulting in death): a. UTERINE CANCER

Dua to (or as a consequanca of):

Sequentiatly list conditions, if any, leading to immedieta cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b.
Dua to (or as a consequance of):
c.
Due to (or es a consequance of):
d.

Part II. **Other significant conditions** contributing to death but not rasulting in the underlying ceuse givan in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yas 2☒ No

24b. Ware eutopsy findings available prior to completion of causa of death? 1☐ Yas 2☐ No

25. Was casa referred to medical examinar? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatiant 2☐ ER/Outpetient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 6☒ Othar *(Specify)* HOSPICE

27. Mennar of Death: 1☒ Natural 2☐ Accident 3☐ Suicida 4☐ Homicida 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury M
28c. Injury at Work? 1☐ Yas 2☐ No
28d. Describe how injury occurred
28e. Piaca of tnjury - At home, ferm, straat, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To tha best of my knowledga, daath occurred at tha tima, data and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On tha basis of axamination and/or investigation, in my opinion, daath occurred at the time, date and piece, and due to tha cause(s) and mannar stated.

29b. Signetura and titia of certifier:
29c. Licanse number: D43725
29d. Data signed *(Month, Day, Year)*: 4/2/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): DR. TARIQ MAHMOOD 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093

State Registrar

31. Data filed *(Month, Day, Year)*: APR 0 3 2001
32. Registrar's Signature: Jeanne G Sparks

ORIGINAL

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
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Important: If item 27 is marked other than "natural", or items 28a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

APRIL 1, 2001 2:00 a.m.

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

PATRICIA VERGARA

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 10160

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: FRED G. WHITE, SR.

2. Date of Death — Month: March; Day: 29; Year: 2001

3. Time of Death: 08:21 AM

4a. Facility Name *(If not institution, give street and number)*: Sinai Hospital of Baltimore

4b. City, Town, or Location of Death: Baltimore City

4c. County of Death: N/A

Funeral Director

5. Social Security Number: 238 40 0297

6. Sex: 1 [X] M 2 [ ] F

7. Age *(In yrs. last birthday)*: 73 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: JUN25,1927

9. Birthplace *(State or Foreign Country)*: N.C.

Usual Residence of Decedent

10a. State: MD.

10b. County: BALTO.

10c. City, Town or Location: RANDALLSTOWN

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 3806 BYXBEE ROAD

10f. Zip Code: 21133

10g. Citizen of What Country?: U.S. OF A.

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* BLACK

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12TH; College (1-4or 5+): UNKNOWN

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: TRACTOR TRAILER DRIVER

16b. Kind of Business/Industry: TRANSPORTATION

17. Father's Name *(First, Middle, Last)*: FREDDIE GOLDEN WHITE

18. Mother's Name *(First, Middle, Maiden Surname)*: SUDIE MAE BROWN

19a. Informant's Name/Relationship *(Type, Print)*: GERALDINE T. WHITE (WIFE)

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 3806 BYXBEE RD. RANDALLSTOWN, MD 21133

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: ARBUTUS MEMORIAL PK. Date: 4/6/01

20c. Location - City or Town, State: BALTO., MD.

21. Signature of Funeral Service Licensee: Lewis T. Gwynn

22. Name and Address of Facility: LEWIS T. GWYNN LEWIS T. GWYNN FUNERAL HOME 21215-4517 PARK HEIGHTS AVENUE BALTIMORE MD

Physician /Medical Examiner

23e. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Hypoxemia

Due to (or as a consequence of):

b. Aspiration Pneumonia

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c. Dysphagia

Due to (or as a consequence of):

d. Cerebrovascular Accident

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Normal Pressure Hydrocephalus, Chronic subdural hematomas, hypertension, seizure disorder, chronic renal insufficiency

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [X] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [ ] No

26. Place of Death *(Check only one)*: Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other *(Specify)*

27. Manner of Death: 1 [ ] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier *(Check only one)*: 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination end/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: MD

29c. License number: RES 000

29d. Date signed *(Month, Day, Year)*: March 29, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Kristin E. Erickson, MD Sinai Hospital 2401 W. Belvedere Ave Balt, MD 21215

State Registrar

31. Date filed *(Month, Day, Year)*: APR 03 2001

32. Registrar's Signature: Geneva G Sparks

DHMH 16 Rev 6/95

ORIGINAL

To be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If Item 27 is marked other than "natural", or Item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

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Division of Vital Records, P.O. Box 68760,

White Sr, Fred G

01-1756-510 William T. Williams
B.K.S
UNKNOWN 01-068

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

1- For State Registrar

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 10161

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
WILLIAM T. WILLIAMS	MARCH 30, 2001	1305 P M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
1902 PATTERSON PARK	BALTIMORE	NA

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
216-54-1406	1☒M 2☐F	50 Yrs.			DEC 23, 1950	NC

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	NA	BALTIMORE	1☒Yes 2☐No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
3915 CALLOWAY AVE APT. 710	21215	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☒Never Married 2☐Married 3☐Widowed 4☐Divorced	1☐Yes 2☒No If Yes, Give Year or Dates:	1☐Yes 2☒No Specify:	Specify: AFRICAN AMERICAN

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
10th	NA	NA	NA

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
SPRUILL WILLIAMS	ELIZABETH JONES

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
JAMES WILLIAMS (BROTHER)	1262 COURTNEY LANE HARFORD COUNTY MD 21017

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	MT ZION CEMTERY	4/4/2001	LANSDOWNE, MD

21. Signature of Funeral Service Licensee ▶

22. Name and Address of Facility: WYLIE FUNERAL HOME PA 638 N. GILMOR STREET BALTIMORE, MD 21217

Physician /Medical Examiner

25a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Multiple Stab and Cutting Wounds	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of):	
	c. Due to (or as a consequence of):	
	d. Due to (or as a consequence of):	

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐Yes 2☐No 9☐Unknown

23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown

23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

24a. Was an autopsy performed? 1☒Yes 2☐No

24b. Were autopsy findings available prior to completion of cause of death? 1☒Yes 2☐No

25. Was case referred to medical examiner? 1☒Yes 2☐No

26. Place of Death (Check only one)
Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA
Other: 4☐Nursing Home 5☐Residence 8☒Other (Specify) AT SCENE

27. Manner of Death 1☐Natural 2☐Accident 3☐Suicide 4☒Homicide 5☐Pending investigation 6☐Could not be determined

28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
UNK	UNK M	1☐Yes 2☒No	Subject stabbed and cut

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Abandoned building

28f. Location (Street and Number or Rural Route Number, City or Town, State) 1902 Patterson Park

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one)
1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated.
2☒ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, end due to tha cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ J. Clifton Locke MD	O.C.M.E	MARCH 31, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
J. CLIFTON LOCKE, MD 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
APR 0 3 2001	▶ Geneva G Sparks

DHMH 17 Rev 1/2001

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
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Physician /Medical Examiner

Division of Vital Records, P.O. Box 68760,

Typing Hospital or Attending Physician: The law requires that the death certificate be executed within 72 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 10162

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Sharon Whittington
2. Date of Death: Month April Day 1 Year 2001
3. Time of Death: 2:30PM
4a. Facility Name (If not institution, give street and number): NORTH WEST HOSPITAL CENTER
4b. City, Town, or Location of Death: RANDALLSTOWN
4c. County of Death: BALTIMORE

Funeral Director

5. Social Security Number: 214-56-6125
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 49 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): JUNE 9 1951
9. Birthplace (State or Foreign Country): MARYLAND

Usual Residence of Decedent

10a. State: MARYLAND
10b. County: N/A
10c. City, Town or Location: BALTIMORE
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 1727 N. APPLETON STREET
10f. Zip Code: 21217
10g. Citizen of What Country? U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: BLACK

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12th grade; College (1-4or 5+): 2yrs
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): DATABASE MANAGER
16b. Kind of Business/Industry: UNIV PHYSICIANS INC.

17. Father's Name (First, Middle, Last): SAMUEL L SMITH
18. Mother's Name (First, Middle, Maiden Surname): MAXINE HOPE TOLBERT

19a. Informant's Name/Relationship (Type, Print): Pamela Drummond/Daughter
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1533 Kirkwood Rd., Baltimore, Maryland 21207

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): KING MEMORIAL PARK
Date: 4-6-01
20c. Location - City or Town, State: BALTIMORE, MARYLAND

21. Signature of Funeral Service Licensee: Charles J. Powell
22. Name and Address of Facility: WILLIAM C BROWN COMMUNITY FUNERAL HOME PA, 1206 W NORTH AVENUE

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiec or respiratory arrest, shock, or heert failure. List only one cause on eech line.

Approximate Interval Between Onset and Death

Immediate Cause (Finai disease or condition resulting in death)
a. Adult respiratory distress syndrome
Due to (or as a consequence of):
b. Systemic inflammatory response syndrome
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Pancytopenia
Protein energy malnutrition
lymphoma

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No
26. Place of Death (Check only one): Hospital: 1☑ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: J Boston MD
29c. License number: D28462
29d. Date signed (Month, Day, Year): April 1, 2001
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): J. Boston Northwest Hospital Center Randallstown, Maryland

State Registrar

31. Date filed (Month, Day, Year): APR 0 3 2001
32. Registrar's Signature: G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 10163

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Mary Virginia Webster
2. Date of Death Month / Day / Year: APRIL 2, 2001
3. Time of Death: 2:55am
4a. Facility Name *(If not institution, give street and number)*: 3933 Stansbury Mill Road
4b. City, Town, or Location of Death: Monkton
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 219-42-1109
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 76 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: JUNE 5, 1924
9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residance of Decedent

10a. State: Maryland
10b. County: Baltimore
10c. City, Town or Location: Monkton
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 3933 Stansbury Mill Road
10f. Zip Code: 21111
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Nevar Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedant Evar in U.S. Armed Forces? 1☐ Yes 2☒ No If Yas, Giva Yaer or Detes:
13. Was Decedent of Hispanic Origin? (Specify Yas or No- If Yes, specify Cuban, Maxican, Puarto Rican, atc.) 1☐ Yas 2☒ No *Specify:*
14. Race - Amarican Indian, Black, Whita, atc. *Specify:* White

15. Decedent's Education *(Specify only highast grada completed)*: Elementary/Secondary (0-12); College (1-4or 5+): 4
16a. Decedent's Usual Occupation *(Giva kind of work dona during most of working lifa. DO NOT usa retired)*: Librarian
16b. Kind of Business/Industry: Public School System

17. Fathar's Name *(First, Middla, Last)*: Edward G. Rost
18. Mothar's Nama *(First, Middla, Maiden Sumama)*: Myrtle Hodge

19a. Informant's Name/Ralationship *(Type, Print)*: David M. Webster/Son
19b. Mailing Address *(Straat and Number or Rural Route Number, City or Town, Stata, Zip Code)*: 10702 Cardington Way #103 Cockeysville, MD 21030

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Othar *(Specify)*
20b. Place of Disposition *(Nama of cematary, crematory or othar placa)*: Metro Crematory Inc.
Date: 4-2-01
20c. Location - City or Town, Stata: Baltimore, MD

21. Signature of Funeral Service Licensee: Thomas Gregor
22. Nama and Address of Facility: Cremation Society of MD, Inc. 299 Frederick Road Baltimore, MD 21228

Physician /Medical Examiner

23a. Part1. Enter tha disaase, or complications that caused tha daath. Do not antar tha moda of dying, such es cardiac or raspiratory arrast, shock, or haart failura. List only ona causa on each lina.

Approximata Interval Batwaan Onset and Death

Immediate Cause (Finai disaasa or condition rasulting in daath)
a. Sarcoma of Abdomen — 2years
Dua to (or as a consequanca of):

Sequantially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disaase or injury that initiated avants rasulting in death) Last
b.
Due to (or es a consequance of):
c.
Dua to (or as a consequance of):
d.

Part II. **Other significant conditions** contributing to death but not rasulting in tha undarlying causa givan in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yas 2☒ No
24b. Wara autopsy findings available prior to completion of cause of death? 1☐ Yas 2☐ No

25. Was casa rafarrad to medical examinar? 1☐ Yas 2☒ No
26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatiant 2☐ ER/Outpatient 3☐ DOA; Othar: 4☐ Nursing Homa 5☒ Rasidanca 6☐ Other *(Specify)*

27. Mannar of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicida 5☐ Pending investigation 6☐ Could not be datarmined
28a. Placa of injury - At home, farm, street, factory, office building, atc. *(Specify)*
28b. Tima of Injury
28c. Injury at Work? 1☐ Yas 2☐ No
28d. Dascribe how injury occurred
28e. Data of Injury *(Month, Day Year)*
28f. Location *(Street and Number or Rural Routa Number, City or Town, Stata)*

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To tha best of my knowladga, death occurred at the time, data and placa, and due to tha causa(s) and mannar as stated. 2☐ **Medical Examiner:** On tha basis of axaminetion and/or investigation, in my opinion, daath occurred at tha time, dete end piece, and due to the cause(s) and mennar steted.

29b. Signatura and title of certifier: Charles Padgett MD
29c. License number: D15546
29d. Data signed *(Month, Day, Year)*: April 2, 2001

30. Nama and address of person who completed cause of death (Item 23a) (Type, Print): Charles Padgett, MD, 5601 Loch Raven Blvd., Baltimore, MD 21239

State Registrar

31. Date filed *(Month, Day, Year)*: APR 0 3 2001
32. Registrar's Signatura: Geneva G Sparks

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 10164

NAME KNOWN TO PHYSICIAN: WRIGHT, ARTHUR

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: ARTHUR WRIGHT
2. Date of Death Month Day Year: MARCH 28, 2001
3. Time of Death: 5:25 PM
4a. Facility Name *(If not institution, give street and number)*: VA MARYLAND HEALTH CARE SYSTEM
4b. City, Town, or Location of Death: PERRY POINT
4c. County of Death: CECIL

Funeral Director

5. Social Security Number: 221-12-7212
6. Sex: 1 [X] M 2 [ ] F
7. Age *(In yrs. last birthday)*: 77 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: AUG 9 1923
9. Birthplace *(State or Foreign Country)*: DELAWARE

Usual Residence of Decedent

10a. State: MARYLAND
10b. County: HARFORD
10c. City, Town or Location: EDGEWOOD
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 1909 ELOISE LANE
10f. Zip Code: 21040
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: 43/45
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* BLACK

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12th grade; College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: CONTRACTOR
16b. Kind of Business/Industry: SELF EMPLOYED

17. Father's Name *(First, Middle, Last)*: RALPH HENRY JONES
18. Mother's Name *(First, Middle, Maiden Surname)*: unknown

19a. Informant's Name/Relationship *(Type, Print)*: Marshall L. McClaine/Brother
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 480 Eastern Ct., Aberdeen, Md., 21001

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*
20b. Place of Disposition *(Name of cemetary, crematory or other place)*: GARRISON FOREST VETERANS
Date: 4-3-01
20c. Location - City or Town, State: OWINGS MILLS, MARYLAND

21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: WILLIAM C BROWN COMMUNITY FUNERAL HOME-HARFORD PA
321 S PHILADELPHIA BLVD, ABERDEEN, MD 21001

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death):
a. ACUTE MYOCARDIAL INFARCTION — UNKNOWN
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [X] Yes 2 [ ] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No
26. Place of Death *(Check only one)*: Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; Other: 4 [X] Nursing Home 5 [ ] Residence 6 [ ] Other *(Specify)*

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined
28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28a. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

29a. Certifier *(Check only one)*: 1 [X] **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: Melecia Santos M.D.
29c. License number: 151094-1
29d. Date signed *(Month, Day, Year)*: MARCH 28, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): MELECIA SANTOS, M.D., VA MARYLAND HEALTH CARE SYSTEM, PERRY POINT, MD 21902

State Registrar

31. Date filed *(Month, Day, Year)*: APR 03 2001
32. Registrar's Signature: Donna G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 10165

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)			2. Date of Death Month Day Year	3. Time of Death
William	Bosley	Wilhelm	March 29, 2001	2:59 PM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Holy Cross Hospital	Silver Spring	Montgonery

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Deys	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
160-14-7209	1 [X] M 2 [ ] F	86 Yrs.			June 26, 1914	MD

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	Montgonery	Colesville	1 [ ] Yes 2 [X] No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
904 Cannon Road	20904	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced	1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:	1 [ ] Yes 2 [X] No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	18b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
	4	Inspector	Federal Goverment

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
William Webster Wilhelm	Eleanor Gorsuch Bosley

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Daniel Wilhelm/Son	904 Cannon Road Colesville, MD 20904

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	Monkton United Methodist Church	April 2,2001	Monkton, MD

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
Michael J. Flagle	Lemmon Funeral Home of Dulaney Valley, Inc. 10 W. Padonia Road Timonium, MD 21093

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Pneumonia, Aspiration	2 1 day
Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disaase or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of): Recurrent Ileus	1 yr
	c. Due to (or as a consequence of):	
	d. Due to (or as a consequence of):	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Data of delivery
1 [ ] Yes 2 [ ] No 9 [ ] Unknown	1 [ ] Live birth 2 [ ] Fetal death 3 [ ] Ectopic pregnancy 4 [ ] Pregnant at time of death 5 [ ] Other (specify) _____ 9 [ ] Unknown	Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Paroxysmal Atrial Fibrillation, Anemia, Dementia, Hypothyroidism

23e. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [✓] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1 [ ] Yes 2 [✓] No	1 [ ] Yes 2 [✓] No

25. Wes cese relerred to medical examiner?	28. Place of Death (Check only one)	
1 [ ] Yes 2 [✓] No	Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA	Other: 4 [✓] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1 [✓] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined		M	1 [ ] Yes 2 [ ] No	
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 [✓] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 [ ] **Medical Examinar:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Dete signed (Month, Day, Year)
MD	D31001	March 30, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Stuart J. Turkewitz, MD. 7500 Greenway Cntr. Dr. #430 Greenbelt, MD. 20770.

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
APR 03 2001	

DHMH 17 Rev 1/2001

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification; To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 72 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar ADMEND ITEM: #8 FUNERAL HOME G794 4-11-01 WR

Certificate of Death

Reg. No. 2001 10166

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
WADE WHITE	MAR 28 2001	1515 M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Laurel Regional Hospital	Laurel	Prince George's

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
217-34-0424	1 [X] M 2 [ ] F	63 Yrs.			11-16 ~~10/16~~/1937	Washington D.C.

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	Prince George's	Laurel	1 [ ] Yes 2 [X] No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
15448 North Arbory Way	20707	U.S.A.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1 [ ] Never Married 2 [ ] Married 3 [ ] Widowed 4 [X] Divorced	1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:	1 [ ] Yes 2 [X] No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4 or 5+)		
12	0	Highway Inspector	D.C. Government

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Fred F. White, Sr.	Evelyn Hampton

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Lois White-sister in law	16026 Jerald Road, Laurel, MD., 20707

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	Balt./Wash.Crematory	03/30/2001	Laurel, Maryland

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ Heather Brown	7601 Sandy Spring Rd. Fleck Funeral Home Laurel, Maryland, 20707

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-i show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. ACUTE CVA — Days

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. Due to (or as a consequence of): Diabetes mellitus II — Years
c. Due to (or as a consequence of):
d. Due to (or as a consequence of):

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month Day Year
1 [ ] Yes 2 [X] No 9 [ ] Unknown	1 [ ] Live birth 2 [ ] Fetal death 3 [ ] Ectopic pregnancy 4 [ ] Pregnant at time of death 5 [ ] Other (specify) _____ 9 [ ] Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Cancer Prostate Respiratory failure
CRF

23e. Did tobacco use contribute to the cause of death?	24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown	1 [ ] Yes 2 [X] No	1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1 [ ] Yes 2 [X] No	Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA	Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined		M	1 [ ] Yes 2 [ ] No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ Pr. Tam SS	D28998	March 29 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
PRITAM S SAINI MD
9101 Cherry Lane Suite 211 Laurel MD 20708

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
APR 03 2001	▶ Geneva G Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 10167

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Jacob J. Weiland, Sr.

2. Date of Death (Month, Day, Year): March 31, 2001

3. Time of Death: 11:44 a.m.

4a. Facility Name (If not institution, give street and number): Franklin Square Hospital Center

4b. City, Town, or Location of Death: Rosedale

4c. County of Death: Baltimore Co.

Funeral Director

5. Social Security Number: 218-10-8593

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 79 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): November 23, 1921

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Baltimore Co.

10c. City, Town or Location: Perry Hall

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 8641 Saxon Circle

10f. Zip Code: 21236

10g. Citizen of What Country?: United States

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: WWII

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 9 yrs. College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Fire Fighter

16b. Kind of Business/Industry: Baltimore City

17. Father's Name (First, Middle, Last): Emil Weiland

18. Mother's Name (First, Middle, Maiden Surname): Barbara Young

19a. Informant's Name/Relationship (Type, Print): Mrs. Anna M. Weiland / Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 8641 Saxon Circle Baltimore, Md. 21236

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Hilltop Service Corp.

Date: 4/04/2001

20c. Location - City or Town, State: Towson, Maryland

21. Signature of Funeral Service Licensee: Michael E. Canapp

▶ Michael C. Canapp

22. Name and Address of Facility: Leonard J. Ruck, Inc. 5305 Harford Road Baltimore, MD 21214

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Vaso depressor Syncope

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Coronary Artery disease

Due to (or as a consequence of):

c. Asteriosclerosis

Due to (or as a consequence of):

d. Hypertension

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [X] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [X] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ H. Kassamali

29c. License number: D046126

29d. Date signed (Month, Day, Year): April 2, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): H. Kassamali, M.D. 17 Fontana Lane Suite 101 Rosedale, MD 21237

State Registrar

31. Date filed (Month, Day, Year): APR 03 2001

32. Registrar's Signature: ▶ Donna D. Sparks

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Physician or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed/filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If Item 27 is marked other than "natural", or Items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 | 0168

HARRIET E. ANDRE

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: HARRIETT ENNIS ANDRE
2. Date of Death Month Day Year: MARCH 18, 2001
3. Time of Death: 9:15 PM
4a. Facility Name *(If not institution, give street and number)*: CIVISTA MEDICAL CENTER
4b. City, Town, or Location of Death: LAPLATA
4c. County of Death: CHARLES

Funeral Director

5. Social Security Number: 220-22-7752
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 75 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: MARCH 8, 1926
9. Birthplace *(State or Foreign Country)*: MARYLAND

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: MARYLAND
10b. County: CHARLES
10c. City, Town or Location: RISON/INDIAN HEAD
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 3285 CEMETERY ROAD
10f. Zip Code: 20640
10g. Citizen of What Country?: UNITED STATES

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yeer or Detas:
13. Was Decedent of Hispanic Origin? (Specify Yas or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Rece - American Indien, Bleck, White, etc. *Specify:* BLACK

15. Decedent's Education *(Specify only highest grade completed)*: Elementery/Secondary (0-12): 12TH GRADE; College (1-4or 5+):
16a. Decedent's Usuel Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: CUSTODIAN
16b. Kind of Business/Industry: BALTIMORE COUNTY BOARD OF EDUCATION

17. Father's Neme *(First, Middle, Last)*: JAMES ENNIS
18. Mother's Neme *(First, Middle, Maiden Sumeme)*: INDIANA HART ENNIS

19a. Informant's Neme/Relationship *(Type, Print)*: ROMAINE SAVOY / NIECE
19b. Meiling Address *(Street end Number or Rural Route Number, City or Town, State, Zip Code)*: 3070 REEDER PLACE, INDIAN HEAD, MARYLAND 20640

20a. Method of Disposition: 1☒ Burial 2☐ Cremetion 3☐ Removal from Stata 4☐ Donation 5☐ Other *(Specify)*
20b. Piece of Disposition *(Name of cemetery, cremetory or other piece)*: ALEXANDRIA CHURCH CEM.
Date: 3/24/01
20c. Location - City or Town, Stete: RISON, MARYLAND

21. Signature of Funeral Service Licensee: Lydia C. Thornton Johnson
LYDIA C. THORNTON JOHNSON M00583
22. Name end Address of Fecility: THORNTON FUNERAL HOME, P.A. 3439 LIVINGSTON ROAD, INDIAN HEAD, MARYLAND 20640

Physician /Medical Examiner

23a. Part1. Enter the diseese, or complicetions thet caused the death. Do not enter tha moda of dying, such as cardiac or raspiretory arrest, shock, or heert teilure. List only one ceuse on eech line.

Approximate Interval Between Onset and Deeth

Immediete Cause (Finel disease or condition resulting in deeth)
a. Aspiration Pneumonia — Minutes
Due to (or as a consequence of):
b. Metabolic encephalopathy — Days
Due to (or as e consequence of):
c. Adrenal insufficiency — Weeks
Due to (or es e consequence of):
d. Bacteremia — Weeks

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initieted events resulting in death) Last

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
Acute tubular nephosis, Urosepsis
Hypertension

23b. Did tobacco use contributa to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Ware eutopsy findings evailable prior to completion of cause of deeth? 1☐ Yes 2☒ No

25. Wes case refarred to medical examiner? 1☐ Yes 2☒ No
26. Place of Deeth *(Check only one)*: Hospitel: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Homa 5☐ Residenca 6☐ Other *(Specify)*
27. Menner of Death: 1☒ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined
28a. Dete of Injury *(Month, Dey Year)*
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Pleca of Injury - At home, ferm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, Stete)*

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, date end place, end due to the cause(s) end menner as stated. 2☐ **Medical Examiner:** On the besis of examinetion and/or investigetion, in my opinion, deeth occurred at the time, dete and piece, and due to the cause(s) end menner steted.
29b. Signature and title of certifier: ▶ Michael Pimental, DO
29c. License number: H-42445
29d. Data signed *(Month, Day, Year)*: March 19, 2001

30. Name and address of person who completed cause of deeth (Item 23a) (Typa, Print): MICHAEL A. PIMENTAL DO 601 POSTOFFICE ROAD WALDORF MARYLAND 20602

State Registrar

31. Dete filed *(Month, Day, Year)*: MAR 22 2001
32. Registrar's Signature: Brenda G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 10169

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Mabel Ellen Burke

2. Date of Death: Month MARCH Day 17 Year 2001

3. Time of Death: 11:35 AM

4a. Facility Name (If not institution, give street and number): Mariner Health of Bel Air

4b. City, Town, or Location of Death: Bel Air

4c. County of Death: Harford

Funeral Director

5. Social Security Number: 231-16-0935

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 82 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): May 1, 1918

9. Birthplace (State or Foreign Country): North Carolina

Usual Residence of Decedent

10a. State: Maryland

10b. County: Harford

10c. City, Town or Location: Bel Air

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 1025 Southern Drive

10f. Zip Code: 21014

10g. Citizen of What Country? USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Cafeteria Worker

16b. Kind of Business/Industry: Telephone Communication

17. Father's Name (First, Middle, Last): Thomas (u/k) Knowles

18. Mother's Name (First, Middle, Maiden Surname): Margaret (u/k) Leary

19a. Informant's Name/Relationship (Type, Print): Dolores L. Waller / Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1025 Southern Drive, Bel Air, MD 21014

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Hilltop Service Corp.

Date: 3-19-01

20c. Location - City or Town, State: Towson, Maryland

21. Signature of Funeral Service Licensee: [signature]

22. Name and Address of Facility: McComas Funeral Home, P.A.
1317 Cokesbury Road, Abingdon, Maryland 21009

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Chronic pulmonary disease, obstructive. — Due to (or as a consequence of):

b. Respiratory Failure — Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

c. Arteriosclerotic Cardiovascular disease — Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☐ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☐ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☐ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☐ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature] M.D.

29c. License number: D0661

29d. Date signed (Month, Day, Year): 3/19/01

30. Name and address of person who completed cause of death (Item 23a) (Type/Print): [illegible] 663 Revolution St. Havre de Grace MD 21078

State Registrar

31. Date filed (Month, Day, Year): MAR 20 2001

32. Registrar's Signature: [signature] D. Sparks

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Mabel E Burke TM

3

DHMH 16 Rev 6/95

ORIGINAL

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 10170

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): William Leo Braunstein
2. Data of Death: Month March Dey 23, Year 2001
3. Time of Death: 8:18 am
4a. Facility Name (If not institution, give street and number): 2309 Pinefield Road
4b. City, Town, or Location of Death: Waldorf
4c. County of Death: Charles

Funeral Director

5. Social Security Number: 170-03-4304
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 86 Yrs.
If Under 1 Yaar: Months / Deys
If Under 24 Hrs.: Hours / Min.
8. Data of Birth (Month, Day, Year): Sept.25,1914
9. Birthplace (State or Foraign Country): Pennsylvania

Usual Rasidance of Decedant

10a. Stata: Maryland
10b. County: Charles
10c. City, Town or Location: Nanjemoy
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 10535 Ox-Cart Lane
10f. Zip Code: 20662
10g. Citizen of What Country? U.S.A.

11. Marital Status: 1 [ ] Nevar Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forcas? 1 [ ] Yas 2 [X] No If Yas, Give Yaar or Dates:
13. Wes Decedant of Hispanic Origin? (Specify Yas or No- If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - Amaricen Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grada completed): Elamantary/Secondary (0-12): 8 / Collega (1-4or 5+):
16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired): Plasterer
16b. Kind of Business/Industry: Home Contractor

17. Fathar's Nama (First, Middle, Last): Joseph Braunstein
18. Mother's Nama (First, Middle, Maidan Surname): Marie Rumpler Braunstein

19a. Informant's Name/Relationship (Type, Print): David Braunstein/son
19b. Mailing Address (Street and Number or Rural Routa Numbar, City or Town, Stata, Zip Code): 10535 Ox-Cart Ln. Nanjemoy, MD 20662

20a. Mathod of Disposition: 1 [ ] Burial 2 [X] Cramation 3 [ ] Ramoval from Stata 4 [ ] Donation 5 [ ] Othar (Specify)
20b. Piece of Disposition (Nama of cemetary, cramatory or othar placa): Brinsfield-Echols Crematory Date: 03-24-01
20c. Location - City or Town, Stata: Charlotte Hall, MD

21. Signature of Funaral Sarvice Licensee: M00817 [signature]
22. Name and Addrass of Faciity: Arehart-Echols Funeral Home, P.A. P.O. Box 567 La Plata, MD 20646

Physician Medical Examiner

23a. Part1. Enter the disease, or complicetions thet caused tha daath. Do not antar tha moda of dying, such as cerdiac or raspiratory arrast, shock, or haart failure. List only ona ceusa on aach lina. Approximata Intarval Batween Onsat and Death

Immediata Causa (Finel disaasa or condition resulting in death)
a. Pneumonia
Due to (or as a consequance of):
b. Dementia - Alzeimers
Sequantially list conditions, if any, leading to immediata causa. Entar Underlying Cause (Disaase or injury that initiated evants resulting in daath) Last
Due to (or as e consequance of):
c.
Due to (or as e consequance of):
d.

Part II. Other significant conditions contributing to death but not rasulting in tha undarlying causa givan in Part I.
Cardiomyopathy
Atrial Fibrilation
Congestive Heart Failure

23b. Did tobacco use contributa to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yas 2 [X] No
24b. Wara autopsy findings available prior to complation of ceuse of death? 1 [ ] Yas 2 [ ] No

25. Was casa rafarrad to medical axaminar? 1 [ ] Yes 2 [X] No
26. Placa of Death (Check only ona): Hospital: 1 [ ] Inpatiant 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Homa 5 [ ] Residence 6 [X] Othar (Specify) Elderly Group Home

27. Manner of Deeth: 1 [X] Netural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Panding investigation 6 [ ] Could not be datarmined
28a. Data of Injury (Month, Day Yaar)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Dascribe how injury occurred
28a. Piace of Injury - At homa, farm, street, factory, offica building, atc. (Specify)
28f. Location (Street and Number or Rural Routa Number, City or Town, Stata)

29a. Certifier (Check only one): 1 [X] Certifying Physician: To the best of my knowledga, daath occurred at tha tima, data and place, and dua to tha causa(s) and mannar as stated. 2 [ ] Medical Examiner: On the basis of axaminetion and/or invastigation, in my opinion, daath occurred at tha time, dete end place, end due to the ceusa(s) and mannar statad.
29b. Signatura and title of certifier: [signature]
29c. License number: D01069
29d. Data signed (Month, Day, Year): 3-23-01
30. Nama and address of person who completed ceusa of death (Item 23a) (Type, Print): Henry L. Burke, M.D. P.O. Box 2539 LaPlata, MD 20646

State Registrar

31. Data filed (Month, Day, Year): MAR 26 2001
32. Registrar's Signature: [signature] G. Sparks

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To be completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or there 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

Amend Item 19b per F.D. 03/21/2001, Carroll County, wjl

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 10171

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)			2. Date of Death Month	Day	Year	3. Time of Death
Matilda	Augusta	Brightful	March	16	2001	4:05AM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Carroll County General Hospital	Westminster	Carroll

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
215-20-8640	1☐ M 2☒ F	72 Yrs.			June 1, 1928	Maryland

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Carroll	Westminster	1☒ Yes 2☐ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
15 Timber Ridge Dr.	21157	U.S.A.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yas, specify Cuban, Mexican, Puarto Rican, atc.)	14. Race - American Indian, Black, Whita, atc.
1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced	1☐ Yes 2☒ No If Yes, Give Yaar or Dates:	1☐ Yes 2☒ No Specify:	Specify: Black

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elemantary/Secondary (0-12)	College (1-4or 5+)		
12		nurse's aide	hospital

17. Fathar's Nama (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
John Jackson	Olivia Budd

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Jacqulyn V. Costley/ niece	859 Streaker Rd. Sykesville, MD ~~21787~~ 21784

20a. Method of Disposition	20b. Place of Disposition (Name of cematary, crematory or other place)	Date	20c. Location - City or Town, Stata
1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)	St. James Cemetery	3/20/01	New Windsor, MD

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
Catharine O. Hartzler	Hartzler Funeral Home 310 Church St. New Windsor, MD 21776

Physician /Medical Examiner

23a. Part1. Enter tha disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or raspiratory arrest, shock, or heart failura. List only one cause on each line.

		Approximate Intarval Between Onsat and Death
Immediate Causa (Final disaasa or condition resulting in daath)	a. Complex ventricular arrhythmia	1 week
	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that initiated avants resulting in death) Last	b. Severe atherosclerotic heart/vascular disease	years
	Due to (or as a consaquance of):	
	c.	
	Due to (or as a consequence of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Part I.

Hypertension
Diabetes

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to complation of causa of death?
1☒ Yes 2☐ No	1☒ Yes 2☐ No

25. Was cese referred to medical examiner?	26. Place of Death (Chack only ona)	
1☐ Yes 2☒ No	Hospital: 1☒ Inpatiant 2☐ ER/Outpatient 3☐ DOA	Other: 4☐ Nursing Homa 5☐ Residence 6☐ Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Panding invastigation 6☐ Could not be datarmined		M	1☐ Yes 2☐ No	
	28a. Place of Injury - At homa, farm, street, factory, office building, atc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1☒ **Certifying Physician**: To tha best of my knowledge, death occurred at the time, date and place, and due to the causa(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of axamination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and mannar stated.

29b. Signature and title of certifiar	29c. License number	29d. Date signed (Month, Day, Year)
Ann Reed	D41843	March 16, 2001

30. Name and address of person who completed ceuse of death (Item 23a) (Type, Print)
Ann Reed - Carroll County General Hospital
200 Memorial Ave Westminster, MD 21157

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
MAR 2 0 2001	Geneva G Sparks

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Matilda A. Brightful

WJL 6

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 10172

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)		2. Date of Death Month Day Year	3. Time of Death
JENNIE	BREIGHNER	MARCH 17, 2001	5:05 PM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
1492 ALGONQUIN Ct.	FINKSBURG	CARROLL

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
218-10-2623	1☐M 2☒F	89 Yrs.			6/18/1911	MARYLAND

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD.	CARROLL	FINKSBURG	1☐Yes 2☒No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
1492 ALGONQUIN CT.	21048	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐Never Married 2☐Married 3☒Widowed 4☐Divorced	1☐Yes 2☒No If Yes, Give Year or Dates:	1☐Yes 2☒No Specify:	Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12		HOUSEWIFE	HOME MAKER

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
JOHN THOMAS MATTHEWS	SADIE SIMCOE

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
CAROLE J. KRAUS -DAUGHTER	1492 ALGONQUIN CT., FINKSBURG, MD. 21048

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other piece)	Date	20c. Location - City or Town, State
1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	DULANEY VALLEY MEM. GARDENS	3/21/01	TIMONIUM, MD.

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ [signature]	FLETCHER FUNERAL HOME 254 E. MAIN ST., WESTMINSTER, MD. 21157

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Breast CANCER	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of):	
	c. Due to (or as a consequence of):	
	d. Due to (or as a consequence of):	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery
1☐Yes 2☒No 9☐Unknown	1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown	Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?	24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐Yes 2☒No 3☐Probably 4☐Unknown	1☐Yes 2☒No	1☐Yes 2☐No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐Yes 2☒No	Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA	Other: 4☐Nursing Home 5☒Residence 6☐Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Dey Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined		M	1☐Yes 2☐No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Dey, Year)
▶ Walter Koppel MD	D15538	3/19/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
WALTER KOPPEL 1900 E. NORTHERN PARKWAY, BALTIMORE, MD. 21239

State Registrar

31. Date filed (Month, Dey, Year)	32. Registrar's Signature
MAR 2 0 2001	▶ Geneva G Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or Items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Medical Certification; To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit.

WJL
10

01-1475-045
GAYLE BERGEN
JVW

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 10173

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)			2. Date of Death (Month, Day, Year)	3. Time of Death
GAYLE	ANNETTE	BERGEN	MARCH 15, 2001	9:31 PM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
NANTICOKE ROAD AND CENTENIAL LANE	HEBRON	WICOMICO

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
442-46-4607	1☐M 2☒F	53 Yrs.			February 6, 1948	Oklahoma

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Wicomico	Quantico	1☐Yes 2☒No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
25343 Club Circle	21856	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐Never Married 2☒Married 3☐Widowed 4☐Divorced	1☒Yes 2☐No If Yes, Give Year or Dates: Navy 8/66-8/69	1☐Yes 2☒No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12	2	Day Care Provider	Child Day Care

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
George Wesley Knapp	Hazel Bell Dewey

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Edwin F. Bergen/Husband	25343 Club Circle, Quantico, MD 21856

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☐Burial 2☒Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	Salisbury Crematory	3/20/01	Salisbury, MD

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ David H. Thompson M0105I	Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804

Physician /Medical Examiner

Medical Certification; To Be Completed by Physician/Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Finat disease or condition resulting in death)	a. MULTIPLE INJURIES	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of):	
	c. Due to (or as e consequence of):	
	d. Due to (or as a consequence of):	

IF FEMALE: 23b. Wes decedent pregnant in the past 12 months? 1☐Yes 2☐No 9☒Unknown	23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetel death 3☐Ectopic pregnency 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown	23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobecco use contribute to the cause of death? 1☐Yes 2☒No 3☐Probebly 4☐Unknown	
24a. Was en autopsy performed? 1☒Yes 2☐No	24b. Were autopsy findings availeble prior to completion of cause of death? 1☒Yes 2☐No

25. Wes case referred to medical examiner? 1☒Yes 2☐No	28. Place of Death (Check only one) Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☐Residence 6☒Other (Specify) SCENE

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☐Natural 2☒Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined	3-15-01	~ 20.00 PM	1☒Yes 2☐No	DRIVER OF CAR IMPACT WITH ANOTHER CAR

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)
ROADWAY	NANTICOKE RD/CENTENIAL, WICOMICO COUNTY

29a. Certifier (Check only one) 1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☒ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ Wayne Ann Shull MD	O.C.M.E.	MARCH 16, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
PHYLLIS D. KORELL 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
MAR 19 2001	▶ Geneva G Sparks

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

10+1VA
DQ

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

1- For State Registrar

Reg. No. 2001 10174

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month / Day / Year	3. Time of Death
William Reese Barkley	MARCH 19 2001	0815 M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
PENINSULA REGIONAL MEDICAL CENTER	SALISBURY	WICOMICO

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
213-14-1401	1☒M 2☐F	77 Yrs.			Jan. 15 1924	Maryland

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Wicomico	Salisbury	1☐Yes 2☒No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
510 Overbrook Drive	21801	U.S.A

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐Never Married 2☒Married 3☐Widowed 4☐Divorced	1☒Yes 2☐No If Yes, Give Year or Dates: WW II	1☐Yes 2☒No Specify:	Specify: Black

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	18b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12		Marine Usmc	None

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
James Barkley	Minnie Price

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Bertha Barkley (Wife)	510 Overbrook DR. Salisbury, Md. 21801

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	Springhill Mem. Garden	3/23/01	Salisbury, Md.

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ Eugene J. Stewart	Stewart Funeral Home 821 West Rd. Salisbury, Md. 21801

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. PNEUMONIA	7 days
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of): METASTATIC CANCER OF THE URINARY BLADDER	6 months
	c. Due to (or as a consequence of):	
	d. Due to (or as a consequence of):	

tF FEMALE: 23b. Was decedent pregnent in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month / Day / Year
1☐Yes 2☐No 9☐Unknown	1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnent at time of death 5☐Other (specify) 9☐Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?	24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐Yes 2☐No 3☑Probably 4☐Unknown	1☐Yes 2☑No	1☐Yes 2☐No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐Yes 2☑No	Hospital: 1☑Inpatient 2☐ER/Outpatient 3☐DOA	Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☑Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined		M	1☐Yes 2☐No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1☑**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ C. Foland MD	D50759	3/20/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
CHARLES FOLASHADE, MD 108 DINEWUFF RD SALISBURY MD 21801

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
MAR 20 2001	▶ Geneva G Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Medical Certification; To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Baltimore, Maryland 21215-0036

William Barkley 213 14 1401

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

GWP

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Amended Item#20a20b,WCHD,dq

Certificate of Death

Reg. No. 2001 10175

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): MELDINE BYRD

2. Date of Death: Month March Day 18 Year 2001

3. Time of Death: 0553

4a. Facility Name (If not institution, give street and number): MALLARD BAY NURSING HOME

4b. City, Town, or Location of Death: CAMBRIDGE

4c. County of Death: DORCHESTER

Funeral Director

5. Social Security Number: 255-50-1647

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 68 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): 11-5-32

9. Birthplace (State or Foreign Country): GEORGIA

Usual Residence of Decedent

10a. State: MD. | 10b. County: WICOMICO | 10c. City, Town or Location: SALISBURY | 10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 28106-ROCKAWALKIN RIDGE RD. | 10f. Zip Code: 21801 | 10g. Citizen of What Country? USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: BLACK

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 9 | College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): DAY CLEANING

16b. Kind of Business/Industry: SELF-EMPLOYED

17. Father's Name (First, Middle, Last): CLARENCE HAGANS

18. Mother's Name (First, Middle, Maiden Surname): ELIZA ROWLS HAGANS

19a. Informant's Name/Relationship (Type, Print): DOROTHY SALTER - SISTER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 28106-ROCKAWALKIN RIDGE RD, SALISBURY, MD. 21801

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Springhill Cemetary / GREENHOLES MEM. PARK | Date: 03-26-01 / 3/25/01 | 20c. Location - City or Town, State: Hebron, Md / SALISBURY, MD.

21. Signature of Funeral Service Licensee: John H Prince

22. Name and Address of Facility: BENNIE SMITH F/H 917-W. ISABELLA ST. SALISBURY, MD. 21801

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. AIDS — 6 mos

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: MD

29c. License number: D2C388

29d. Date signed (Month, Day, Year): March 20, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Michael Fadden MD 302 Collins Ave Hurlock Md 21643

State Registrar

31. Date filed (Month, Day, Year): MAR 20 2001

32. Registrar's Signature: Geneva G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 10176

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Leroy Warren Burkett
2. Date of Death (Month, Day, Year): March 16, 2001
3. Time of Death: 1:40 AM
4a. Facility Name *(If not institution, give street and number)*: Prince Georges County Hospital
4b. City, Town, or Location of Death: Cheverly
4c. County of Death: Prince Georges

Funeral Director

5. Social Security Number: 214-07-5805
6. Sex: 1 ☐ M 2 ☐ F — X
7. Age *(In yrs. last birthday)*: 88 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: May 24, 1912
9. Birthplace *(State or Foreign Country)*: Pennsylvania

Usual Residence of Decedent

10e. State: PA
10b. County: Bedford
10c. City, Town or Location: Hyndman
10d. Inside City Limits: 1 ☐ Yes 2 ☐ No — X
10e. Street and Number: 150 Mill Street
10f. Zip Code: 15545
10g. Citizen of What Country?: USA

11. Marital Status: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No — If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 ☐ Yes 2 ☒ No — Specify:
14. Race - American Indian, Black, White, etc. — Specify: White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 10 | College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Machine operator
16b. Kind of Business/Industry: Manufacturing

17. Father's Name *(First, Middle, Last)*: Simon (MNU) Burkett
18. Mother's Name *(First, Middle, Maiden Surname)*: Bertha (MNU) Gardner

19a. Informant's Name/Relationship *(Type, Print)*: Donald L. Burkett
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 4406 30th Street, Mt. Rainier, MD 20712

20a. Method of Disposition: 1 ☐ Burial 2 ☐ Cremation 3 ☒ Removal from State 4 ☐ Donation 5 ☐ Other *(Specify)* — X
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Madley Cemetery
Date: 3/20/01
20c. Location - City or Town, State: Buffalo Mills, PA

21. Signature of Funeral Service Licensee: ▶ Harvey H Zeigler
22. Name and Address of Facility: Harvey H. Zeigler Funeral Home, 169 Clarence Street, Hyndman, PA 15545

Physician /Medical Examiner

23e. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death):
a. Arteriosclerotic Cardiovascular Disease — Years

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b.

Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Chronic Obstutive Pulmonary disease

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☑ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No

26. Place of Death *(Check only one)*: Hospital: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other *(Specify)*

27. Manner of Death: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury *(Month, Day, Year)*
28b. Time of Injury: M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 ☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ [signature] Internal Medicine
29c. License number: D0056420
29d. Date signed *(Month, Day, Year)*: 3/16/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Peter Wagner, MD 4203 Queensbury Rd, Hyattsville, MD 20781

5 mill

State Registrar

31. Date filed *(Month, Day, Year)*: MAR 19 2001
32. Registrar's Signature: Rebecca G Sparks

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

01-1415-510
CJ
Raymond Bucklew

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 10177

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month	Day	Year	3. Time of Death
Raymond P. Bucklew	March	13	2001	11:00 A.M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Johns Hopkins Bayview Medical Center	Baltimore	N/A

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months	Days	If Under 24 Hrs.: Hours	Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
236-20-0738	1☒M 2☐F	79 Yrs.					Jan. 26,1922	West Virginia

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
WV	Mineral	New Creek	1☐Yes 2☒No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
HC 72, Box 98	26743	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐Never Married 2☐Married 3☒Widowed 4☐Divorced	1☒Yes 2☐No If Yes, Give Year or Dates:	1☐Yes 2☒No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
9		Clerk	United States Postal Service

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Obed B. Bucklew	Florence Goff

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Dale A. Bucklew/Son	P.O. Box 61 New Creek, WV 26743

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	Potomac Memorial Gardens	March 17 2001	Keyser, WV

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ Brian L Smith	Smith Funeral Home 85 S. Main Street Keyser, WV 26726

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory errest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. SEPSIS	
	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. THERMAL INJURIES	
	Due to (or as a consequence of):	
	c.	
	Due to (or as e consequence of):	
	d.	

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐Yes 2☐No 9☐Unknown

23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time ot death 5☐Other (specify) _____ 9☐Unknown

23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given In Part I.

Arteriosclerotic Cardiovascular Disease

Chronic Obstructive Pulmonary Disease

23e. Did tobacco use contribute to the cause of death? 1☒Yes 2☐No 3☐Probably 4☐Unknown

24a. Was an autopsy performed? 1☐Yes 2☒No

24b. Were autopsy findings available prior to completion of cause ot death? 1☐Yes 2☒No

25. Was case referred to medical examiner? 1☒Yes 2☐No

26. Place of Death (Check only one)
Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA
Other: 4☐Nursing Home 5☐Residence 8☐Other (Specify)

27. Manner of Death 1☐Natural 2☒Accident 3☐Suicide 4☐Homicide 5☐Pending investigetion 8☐Could not be determined

28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
2/21/2001	3:30 P.M	1☐Yes 2☒No	Thermal Burns sustained while Smoking during oxygen therapy

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)
Nursing Home	Kayser, West Virginia

29a. Certifier (Check only one)
1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☒ **Medical Examinar:** On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date end place, end due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Dete signed (Month, Day, Year)
▶ J Pestaner, M.D.	O.C.M.E.	March 14, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Joseph Pestaner, M.D. 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Yeer)	32. Registrar's Signature
MAR 19 2001	▶ Geneva G Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

15

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 10178

228-24-1860

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified as soon as possible.

Physician /Medical Examiner

Funeral Director

To Be Completed by Funeral Director

1. Decedent's Name (First, Middle, Last)	2. Date of Death (Month / Day / Year)	3. Time of Death
Raymond Roland Cook	March 18 2001	1328

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
PENINSULA REGIONAL MEDICAL CENTER	SALISBURY	WICOMICO

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
228-24-1860	1☒ M 2☐ F	71 Yrs.			August 8, 1929	Virginia

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Wicomico	Salisbury	1☐ Yes 2☒ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
504 Purnell Road	21801	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced	1☐ Yes 2☒ No If Yes, Give Year or Dates:	1☐ Yes 2☒ No Specify:	Specify: Black

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
6th		laborer	Perdue, Inc.

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
John Cook	Betty Garrison

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Roberta Cook/wife	504 Purnell Road - Salisbury, MD 21801

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)	Calvary UM Church Ceme.	03/24/01	Fruitland, Maryland

21. Signature of Funeral Service Licensee: Patricia A Jolley

22. Name and Address of Facility: 1213 Jersey Road - Salisbury, MD
Jolley Memorial Chapel 21801

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit pass.

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Acute Exacerbation of COPD	
	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b.	
	Due to (or as a consequence of):	
	c.	
	Due to (or as a consequence of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☑ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐ Yes 2☑ No	1☐ Yes 2☑ No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐ Yes 2☑ No	Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☑ DOA	Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined		M	1☐ Yes 2☐ No	
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
[signature] M.D.	D50759	03/19/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
CHARLES FOLAS HADEMENOS 108 PINEBLUFF RD SALISBURY MD 21801

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
MAR 20 2001	Geneva G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Raymond Cook

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 10179

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): William Ward Conley

2. Date of Death: Month MARCH Day 24 Year 2001

3. Time of Death: 1:44 AM

4a. Facility Name (If not institution, give street and number): MEMORIAL HOSPITAL & MEDICAL CENTER

4b. City, Town, or Location of Death: CUMBERLAND

4c. County of Death: ALLEGANY

Funeral Director

5. Social Security Number: 214-05-6932

6. Sex: 1☐M 2☐F — X

7. Age (In yrs. last birthday): 90 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Feb 15, 1911

9. Birthplace (State or Foreign Country): WV

Usual Residence of Decedent

10a. State: MD

10b. County: Allegany

10c. City, Town or Location: Cumberland

10d. Inside City Limits: 1☐Yes 2☐No — X

10e. Street and Number: 309 E. Oldtown Road

10f. Zip Code: 21502

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐Yes 2☒No — If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puarto Rican, atc.): 1☐Yes 2☐No — X — Specify:

14. Race - American Indian, Black, White, etc. Specify: white

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Clerk

16b. Kind of Business/Industry: A&P Tea Company

17. Father's Name (First, Middle, Last): Ellis Conley

18. Mother's Name (First, Middle, Maiden Surname): Marjorie (Waltz)

19a. Informant's Name/Relationship (Type, Print): Mary Ann McIntyre Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): P.O. Box 219;Hurst IL 62949

20a. Method of Disposition: 1☒ Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other piece): Sunset Memorial Park

Date: 3/28/2001

20c. Location - City or Town, State: Cumberland, MD

21. Signature of Funeral Service Licensee: Nicholas J. Scarpelli

22. Name and Address of Facility: Scarpelli Funeral Home, P.A. Cumberland, MD 21502

To Be Completed by Funeral Director

WILLIAM W. CONLEY 214-05-6932
Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or haart failura. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. CORONARY ARTERY DISEASE — 7 YEARS

Due to (or as a consequence of):

b. RENAL FAILURE — 2 YEARS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c.

Due to (or as a consequenca of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contributs to the cause of death? 1☐Yes 2☐No 3☐Probably 4☒Unknown

24a. Was en autopsy performed? 1☐Yes 2☒No

24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☐No

25. Was casa referred to medical examiner? 1☐Yes 2☒No

26. Place of Death (Check only one): Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death: 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐Yes 2☐No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

29a. Cartifier (Check only one): 1☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ Medical Examiner: On the basis of examination and/or Investigetion, in my opinion, deeth occurred et the time, dete and pleca, and due to the ceuse(s) and manner steted.

29b. Signature and title of certifier: D. Poonai

29c. Licensa number: D 36766

29d. Data signed (Month, Day, Year): MARCH 24, 2001

6

30. Nama and address of person who completed cause of death (Item 23a) (Type, Print): DR. VIK POONAI, SETON DRIVE, CUMBERLAND, MARYLAND 21502

State Registrar

31. Dateflled (Month, Day, Year): MAR 26 2001

32. Registrar's Signature: Barbara P Sparks

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 10180

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: JOSEPH DONALD CHARNOCK
2. Date of Death Month Day Year: March 19, 2001
3. Time of Death: 3:30 PM
4a. Facility Name *(If not institution, give street and number)*: 15597 PRINCE FREDERICK ROAD
4b. City, Town, or Location of Death: HUGHESVILLE
4c. County of Death: CHARLES

Funeral Director

5. Social Security Number: 215-36-4763
6. Sex: 1 [X] M 2 [ ] F
7. Age *(In yrs. last birthday)*: 60 Yrs. If Under 1 Year: Months / Days. If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: FEBRUARY 26, 1941
9. Birthplace *(State or Foreign Country)*: MARYLAND

Usual Residence of Decedent

10a. State: MARYLAND
10b. County: CHARLES
10c. City, Town or Location: HUGHESVILLE
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 15597 PRINCE FREDERICK ROAD
10f. Zip Code: 20637
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* WHITE

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12; College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: TRUCK DRIVER
16b. Kind of Business/Industry: GIANT FOOD

17. Father's Name *(First, Middle, Last)*: IRA CHARNOCK
18. Mother's Name *(First, Middle, Maiden Surname)*: VIOLA LUCAS

19a. Informant's Name/Relationship *(Type, Print)*: FELICIA S. CHARNOCK/WIFE
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: P.O. BOX 448, HUGHESVILLE, MD 20637

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: OLDFIELDS EPISCOPAL CHURCH
Date: 3/24/2001
20c. Location - City or Town, State: HUGHESVILLE, MD

21. Signature of Funeral Service Licensee: MARK G. BROHAWN M00053
22. Name and Address of Facility: Huntt Funeral Home, Inc. P. O. Box 156, Waldorf, MD 20604

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

JPK

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. RESPIRATORY FAILURE
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
b. AMYOTROPHIC LATERAL SCLEROSIS
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: HYPERTENSION

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No
26. Place of Death *(Check only one)*: Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; Other: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other *(Specify)*
27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

29a. Certifier *(Check only one)*: 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: V. Anmangandla
29c. License number: D26064
29d. Date signed *(Month, Day, Year)*: 3-20-01

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): Vidyasagar Anmangandla, P. O. Box 282, Rt. 5 & Golden Beach Rd., Charlotte Hall, MD 20622

State Registrar

31. Date filed *(Month, Day, Year)*: MAR 22 2001
32. Registrar's Signature: Denise G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 10181

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: LIDA J. DALTON

2. Date of Death — Month: March; Day: 17; Year: 2001

3. Time of Death: 11:35 pm

4a. Facility Name *(If not institution, give street and number)*: GOOD SAMARITAN HOSPITAL

4b. City, Town, or Location of Death: BALTIMORE

4c. County of Death: - -

Funeral Director

5. Social Security Number: 212-38-2698

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 96 Yrs.

If Under 1 Year — Months: ; Days:

If Under 24 Hrs. — Hours: ; Min.:

8. Date of Birth *(Month, Day, Year)*: 5/24/1904

9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: MD.

10b. County: Harford

10c. City, Town or Location: Baldwin

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 2610 Baldwin Mill Road

10f. Zip Code: 21013

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* Caucasian

15. Decedent's Education *(Specify only highest grade completed)*

Elementary/Secondary (0-12): 11

College (1-4or 5+): 2

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: School Teacher

16b. Kind of Business/Industry: Elementary School

17. Father's Name *(First, Middle, Last)*: John T. Johnson

18. Mother's Name *(First, Middle, Maiden Surname)*: Fannie B. Roberts

19a. Informant's Name/Relationship *(Type, Print)*: Edward H. Dalton /Son

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 2611 Baldwin Mill Rd. Baldwin, Md. 21013

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: St, John Cemetery

Date: 3/22 2001

20c. Location - City or Town, State: Hydes, Maryland

21. Signature of Funeral Service Licensee: M. Gladden Kurtz III

22. Name and Address of Facility: E.G. Kurtz & Son Funeral Home, P.A. Jarrettsville, Maryland

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Pneumonia — Approximate Interval: UnKnown

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as e consequenca of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: MD

29c. License number: p14418

29d. Date signed *(Month, Day, Year)*: March, 17 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): GEORGE SALIBA 5601 LOCH RAVEN BLVD BALTIMORE MD 21239

State Registrar

31. Date filed *(Month, Day, Year)*: MAR 21 2001

32. Registrar's Signature: Donna B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 10182

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Evelyn L. Davidson

2. Date of Death — Month: March; Day: 20; Year: 2001

3. Time of Death: 12:55 am

4a. Facility Name *(If not institution, give street and number)*: Westminster Nursing and Convalescent Ctr.

4b. City, Town, or Location of Death: Westminster

4c. County of Death: Carroll

Funeral Director

5. Social Security Number: 217-36-4134

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 91 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Aug 11 1909

9. Birthplace *(State or Foreign Country)*: MD

Usual Residence of Decedent

10a. State: MD

10b. County: Carroll

10c. City, Town or Location: Westminster

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 1234 Washington Road

10f. Zip Code: 21157

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No — If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)* — Elementary/Secondary (0-12): — College (1-4or 5+): 1

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Farmer

16b. Kind of Business/Industry: Farming

17. Father's Name *(First, Middle, Last)*: Denton Leister

18. Mother's Name *(First, Middle, Maiden Surname)*: Sarah Dreschler

19a. Informant's Name/Relationship *(Type, Print)*: Allan Davidson/son

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 2625 Lawndale Rd Finksburg, MD 21048

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Leisters Church Cem — Date: 3/23/2001

20c. Location - City or Town, State: Westminster, MD

21. Signature of Funeral Service Licensee: R. G. Pritts

22. Name and Address of Facility: Pritts Funeral Home and Chapel, 412 Washington Rd Westminster, MD 21157

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Pulmonary Fibrosis — Ten years

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Hypertension

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death *(Check only one)* — Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☑ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: MD

29c. License number: D33184

29d. Date signed *(Month, Day, Year)*: March 20, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Jonathan Kushner 114 Business Center Drive Reisterstown, MD 21136

State Registrar

31. Date filed *(Month, Day, Year)*: MAR 2 0 2001

32. Registrar's Signature: Geneva G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

WJL 10

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 10183

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death (Month, Day, Year)	3. Time of Death
Katherine E. Del Negro	March 15, 2001	12:15 pm

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Corsica Hills Nursing Home	Centreville	Queen Annes

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
215-10-3493	1☐ M 2☒ F	88 Yrs.			Oct 25, 1912	Maryland

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Queen Annes	Stevensville	1☐ Yes 2☒ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
603 Bayside Drive	21666	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced	1☐ Yes 2☒ No If Yes, Give Year or Dates:	1☐ Yes 2☒ No *Specify:*	*Specify:* white

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
11		Bookkeeper	Dental Company

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
William J. Gunning	Fannie M. Butcher

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Anthony Del Negro, son	603 Bayside Drive, Stevensville, MD 21666

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)	Lorraine Mausoleum	3/19 2001	Baltimore, MD

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ Steven E Cline 100723	Eline Funeral Home 934 South Main St, Hampstead, MD 21074

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	e. Urosepsis	6days
	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b.	
	Due to (or as a consequence of):	
	c.	
	Due to (or as a consequence of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Alzheimers Dementia / DM Type II / HTN.

DM gastroparesis.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐ Yes 2☒ No	1☐ Yes 2☐ No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐ Yes 2☒ No	Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA	Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined		M	1☐ Yes 2☐ No	
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ Neil Stoddard MD	D50996	3/15/01

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Neil Stoddard MD, 100 Brown Street, Chestertown, MD 21620

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
MAR 2 1 2001	▶ Geneva G Sparks

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Katherine Delnegro KC 12:15pm

#215-10-3493

WJL 1

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

1- For State Registrar

Reg. No. 2001 10184

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Gladys B. Dorman

2. Date of Death Month/Day/Year: March 16, 2001

3. Time of Death: 0938 AM

4a. Facility Name (If not institution, give street and number): PENINSULA REGIONAL MEDICAL CENTER

4b. City, Town, or Location of Death: SALISBURY

4c. County of Death: WICOMICO

Funeral Director

5. Social Security Number: 220-03-8127

6. Sex: 1☐M 2☒F

7. Age (In yrs. last birthday): 91 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Feb. 9, 1910

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Wicomico

10c. City, Town or Location: Fruitland

10d. Inside City Limits: 1☐Yes 2☒No

10e. Street and Number: 103 Jefferson Street

10f. Zip Code: 21826

10g. Citizen of What Country?: USA

11. Marital Status: 1☐Never Married 2☐Married 3☒Widowed 4☐Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐Yes 2☒No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No Specify:

14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 7th

College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): domestic

16b. Kind of Business/Industry: housewife

17. Father's Name (First, Middle, Last): Colbourn Barkley

18. Mother's Name (First, Middle, Maiden Surname): Ada Wright

19a. Informant's Name/Relationship (Type, Print): Patricia Wright/niece

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): P. O. Box 42 - Fruitland, Maryland 21826

20a. Method of Disposition: 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Green Acres Mem. Pk.

Date: 03/21/01

20c. Location - City or Town, State: Salisbury, Maryland

21. Signature of Funeral Service Licensee: Patricia A Jolley

22. Name and Address of Facility: 1213 Jersey Road - Salisbury, MD Jolley Memorial Chapel

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final diseese or condition resulting in death)

a. ACUTE BRADYARRYTHMIAS — 5 MINUTES

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Diseese or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

b. SEVERE DEHYDRATION — 2 DAYS

Due to (or as a consequence of):

c. CACHEXIA — 30 DAYS

Due to (or as e consequence of):

d. DEMENTIA — 24 YEARS

IF FEMALE:

23b. Was decedent pregnent in the past 12 months? 1☐Yes 2☒No 9☐Unknown

23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown

23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

ANEMIA

PNEUMONIA

HYPOXIA

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

24a. Was an autopsy performed? 1☐Yes 2☒No

24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☒No

25. Was case relerred to medical exeminer? 1☐Yes 2☒No

26. Place of Death (Check only one) Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death 1☒Netural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐Yes 2☐No

28d. Describe how injury occurred

28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1☒**Certifying Physician:** To the best of my knowledge, death occurred et the time, date and place, and due to the cause(s) and manner as stated. 2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, deeth occurred et the fime, date end place, end due to the cause(s) end manner stated.

29b. Signature and title of certifier: [signature], MD

29c. License number: D46962

29d. Date signed (Month, Dey, Year): MARCH 16, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): M. SHIRAZI, M.D. PENINSULA REGIONAL MEDICAL CENTER, MD 21801

State Registrar

31. Date filed (Month, Day, Year): MAR 20 2001

32. Registrar's Signature: [signature]

DHMH 17 Rev 1/2001

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

Gladys Dorman SSN#

GMP

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 10185

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Guiseppina Denicola

2. Date of Death Month Day Year: March 13, 2001

3. Time of Death: 9:45 pm

4a. Facility Name *(If not institution, give street and number)*: Montgomery Village Care & Rehab Center

4b. City, Town, or Location of Death: Gaithersburg

4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 212-36-7478

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 92 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Apr 18, 1908

9. Birthplace *(State or Foreign Country)*: Italy

Usual Residence of Decedent

10a. State: Maryland

10b. County: Montgomery

10c. City, Town or Location: Damascus

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 24233 Preakness Drive

10f. Zip Code: 20872

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* white

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 | College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Seamstress

16b. Kind of Business/Industry: Clothing

17. Father's Name *(First, Middle, Last)*: Salvator Noto

18. Mother's Name *(First, Middle, Maiden Surname)*: Antopina Spinato

19a. Informant's Name/Relationship *(Type, Print)*: Maria Casalena, sister

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 24233 Preakness Dr, Damascus, MD 20872

20a. Method of Disposition: 1☐ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☒ Other *(Specify)* Crypt

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Lorraine Park Cemetery

Date: 3/16 2001

20c. Location - City or Town, State: Baltimore, MD

21. Signature of Funeral Service Licensee: Steven W Eline MO723

22. Name and Address of Facility: Eline Funeral Home 934 South Main St, Hampstead, MD 21074

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

e. Respiratory failure with hypoxemia — minutes

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Dementia — Yrs.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☒ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: S. Shulfarey, MD

29c. License number: 31391 D

29d. Date signed *(Month, Day, Year)*: March 14 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Dr. Anushiravan, 13219 Executive Park Terrace, Germantown, MD 20874

State Registrar

31. Date filed *(Month, Day, Year)*: MAR 2 1 2001

32. Registrar's Signature: Geneva B Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

WJR 4

01-1664-037
B.K.S
CHRISTINE MARIE For DUPUIS

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- State Registrar AMEND ITEM 23a,27,28a-f per ME G795 050301 SS

Certificate of Death

Reg. No. 2001 10186

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)			2. Date of Death Month	Day	Year	3. Time of Death
Christine	Marie	Dupuis	MARCH	25,	2001	0613 A M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
45861 MOUNTAIN LAUREL WAY	GREAT MILLS	ST.MARY'S

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year Months	Days	If Under 24 Hrs. Hours	Min.	8. Date of Birth (Month, Day, Yeer)	9. Birthplace (State or Foreign Country)
223-80-1517	1☐M 2■F	48 Yrs.					July 23,1952	New Jersey

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	St. Mary's	Great Mills	1☐Yes 2■No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
45861 Mountain Laurel Way	20634	United States

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1■Never Married 2☐Married 3☐Widowed 4☐Divorced	1■Yes 2☐No If Yes, Give Year or Dates:	1☐Yes 2■No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
	3	Student	College

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Francis Dyson Dupuis	Dorothy Ethel Gilmore

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20634
Francis Dyson Dupuis / Father	45861 Mountain Laurel Way, Great Mills, Maryland

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☐Burial 2■Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	Crematory Brinsfield-Echols	3/30/2001	Charlotte Hall,MD

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
Edward N. Brinsfield,Jr. M00052	Brinsfield Funeral Home, P.A. 22955 Hollywood Road, Leonardtown, MD 20650-0279

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. HEAD INJURIES COMPLICATING SEIZURE DISORDER	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of):	
	c. Due to (or as a consequence of):	
	d. Due to (or as a consequence of):	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month Day Year
1☐Yes 2☒No 9☐Unknown	1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☐Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☒Yes 2☐No	1☒Yes 2☐No

25. Was case referred to medical examiner?	28. Place of Death (Check only one)
1☒Yes 2☐No	Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☐Residence 6☒Other (Specify) XX AT SCENE

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☐Natural 2☒Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined	3-24-01	10 PM	1☐Yes 2☒No	subject fell out of bed

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)
home	45861 Mountain Laurel Way, Great Mills, MD

29a. Certifier (Check only one) 1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
XX 2☒ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
[signature]	O.C.M.E	MARCH 26, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
J. Alton Locke, MD 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
MAR 29 2001	[signature]

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

Medical Certification:

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

ADMEND ITEM: #23 PART I PER PHY G794 4-2-01 WC

Certificate of Death

Reg. No. 2001 10187

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)			2. Date of Death Month Day Year	3. Time of Death
Carl	Howard	Dye	February 16, 2001	3:00 AM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
St. Mary's Nursing Center	Leonardtown	St. Mary's

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
448-10-3701	1☒ M 2☐ F	87 Yrs.			Feb. 15, 1914	Nebraska

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Charles	LaPlata	1☒ Yes 2☐ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
413 Linden Lane	20646	U S A

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced	1☐ Yes 2☒ No If Yes, Give Year or Dates:	1☐ Yes 2☒ No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
11th Grade		Heavy Equipment Operator	Metal Salvage Yard

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Joseph Dye	Myrtle Rumley

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Mrs. Frankye Dye (Wife)	413 Linden Lane, LaPlata, Maryland 20646

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)	Brinsfield-Echols	2/17/2001	Charlotte Hall, MD

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
Mary Rizzo Mullin	Brinsfield-Echols Funeral Home, P.A. P.O. Box 128, Charlotte Hall, Maryland 20622

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. CARDIOPULMONARY FAILURE

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Cardiopulmonary failure	hrs
	Due to (or as a consequence of): CHRONIC RENAL FAILURE	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	b. Chronic Renal Failure	wks.
	Due to (or as a consequence of): CORONARY ARTERY DISEASE	
	c.	
	Due to (or as a consequence of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Coronary Artery D.
Congestive Heart Failure

23b. Did tobacco use contribute to the cause of death?	24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown	1☐ Yes 2☒ No	1☐ Yes 2☐ No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐ Yes 2☒ No	Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA	Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined		M	1☐ Yes 2☐ No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
J. Patrick Jarboe MD	D 06419	2-19-01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
J. Patrick Jarboe, MD Hollywood, Maryland 20636

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
FEB 20 2001	

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 10188

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Natasha Marie Frye

2. Date of Death — Month: MARCH Day: 20 Year: 2001

3. Time of Death: 0500

4a. Facility Name *(If not institution, give street and number)*: Upper Chesapeake Medical Center

4b. City, Town, or Location of Death: Bel Air

4c. County of Death: Harford

Funeral Director

5. Social Security Number: 415-50-1362

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 66 Yrs.

If Under 1 Year — Months: Days:

If Under 24 Hrs. — Hours: Min.:

8. Date of Birth *(Month, Day, Year)*: Sept. 16, 1934

9. Birthplace *(State or Foreign Country)*: Kentucky

Usual Residence of Decedent

10a. State: Maryland

10b. County: Harford

10c. City, Town or Location: Joppa

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 626 C. Harborside Drive

10f. Zip Code: 21085

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education *(Specify only highest grade completed)*: Elementery/Secondery (0-12): 12 College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Credentialer

16b. Kind of Business/Industry: Medical School

17. Father's Name *(First, Middle, Last)*: William Homer Hartsock

18. Mother's Name *(First, Middle, Maiden Surname)*: Gladys Mae Hall

19a. Informant's Name/Relationship *(Type, Print)*: John E. Frye / Husband

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 626-C Harborside Drive, Joppa, Maryland 21085

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Hilltop Service Corp.

Date: 3-21-01

20c. Location - City or Town, State: Towson, Maryland

21. Signature of Funeral Service Licensee: Stephen A Hughes

22. Name and Address of Facility: McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. CONJESTIVE HEART FAILURE — YEARS

Due to (or as a consequence of):

b. CARDIOMYOPATHY — YEARS.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☒ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day, Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Dean L Vassar

29c. License number: D0016036

29d. Date signed *(Month, Day, Year)*: MARCH 20, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): DEAN VASSAR 520 Upper Chesapeake Dr. Ste 201 Bel Air Md 21014

State Registrar

31. Date filed *(Month, Day, Year)*: MAR 20 2001

32. Registrar's Signature: B. Sparks

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

Frye, Natasha A

10

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 10189

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Dey Year	3. Time of Death
James D. Fisher	March 15, 2001	7:50 P M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
29265 West Line Road	Delmar	Wicomico

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
217-28-4737	1☒M 2☐F	72 Yrs.			April 29, 1928	Tennessee

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	Wicomico	Delmar	1☐Yes 2☒No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
29265 West Line Road	21875	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Rece - American Indian, Bleck, White, etc.
1☐Never Married 2☒Married 3☐Widowed 4☐Divorced	1☒Yes 2☐No If Yes, Give Yeer or Detes: 1945–1948	1☐Yes 2☒No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementery/Secondery (0-12)	College (1-4or 5+)		
	2	Owner/Operator Autobody Shop	Autobody Shop

17. Father's Name (First, Middle, Last)	18. Mother's Neme (First, Middle, Maiden Surname)
Carl M. Fisher	Mildred Ashley Fisher

19a. Informent's Neme/Reletionship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Maria S. Fisher (Wife)	29265 West Line Road Delmar, MD 21875

20e. Method of Disposition	20b. Piece of Disposition (Neme of cemetery, crematory or other place)	Date	20c. Location - City or Town, Stete
1☐Buriel 2☒Cremation 3☐Removel from State 4☐Donation 5☐Other (Specify)	Crematory of Delmarva	March 16, 2001	Delmar, Delaware

21. Signature of Funeral Service Licensee	22. Name end Address of Fecility
	Short Funeral Home 13 E. Grove St. Delmar, DE 19940

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications thet caused the death. Do not enter the mode of dying, such as cardiec or respiratory arrest, shock, or heert failure. List only one cause on eech line.

Approximate Intervel Between Onset and Death

Immediate Cause (Finel disease or condition resulting in deeth)
a. lung CA — Approximate Intervel: 1 month

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury thet initieted events resulting in death) Last
b. Due to (or as e consequence of):
c. Due to (or as e consequence of):
d. Due to (or as e consequence of):

IF FEMALE: 23b. Was decedent pregnent in the past 12 months? 1☐Yes 2☐No 9☐Unknown	23c. If yes, outcome of pregnency 1☐Live birth 2☐Fetel deeth 3☐Ectopic pregnency 4☐Pregnent et time of death 5☐Other (specify) 9☐Unknown	23d. Date of delivery Month Dey Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Pert I.

23e. Did tobacco use contribute to the cause of death? 1☑Yes 2☐No 3☐Probebly 4☐Unknown

24e. Was an eutopsy performed? 1☐Yes 2☑No	24b. Were eutopsy findings available prior to completion of cause of death? 1☐Yes 2☐No

25. Was case referred to medical examiner? 1☐Yes 2☑No	26. Place of Death (Check only one) Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☑Residence 8☐Other (Specify)

27. Menner of Deeth 1☑Netural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigetion 6☐Could not be determined	28a. Dete of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury et Work? 1☐Yes 2☐No	28d. Describe how injury occurred

28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify)

28f. Location (Street and Number or Rurel Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one)
1☑ **Certifying Physician:** To the best of my knowledge, death occurred et the time, date and placa, and due to the cause(s) and menner es stated.
2☐ **Medical Examiner:** On the basis of examinetion and/or investigation, in my opinion, deeth occurred et the time, date and piece, end due to the cause(s) end manner stated.

29b. Signature end Title of Certifier	29c. License number	29d. Dete signed (Month, Day, Year)
MD	D0054127	3/16/01

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)
Alan DAVIS 3 Bistate Blvd Delmar MD 21875

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

10+1VA DQ

State Registrar

31. Date filed (Month, Dey, Yeer)	32. Registrar's Signature
MAR 19 2001	Donna G Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

1- For State Registrar

Reg. No. 2001 10190

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death (Month, Day, Year)	3. Time of Death
Constance Ackerly Gardner	March 16 2001	9:40pm M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
7216 Springfield Avenue	Sykesville	Carroll

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
218-28-1164	1☐M 2☒F	90 Yrs.			Sept 6 1910	NJ

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Md	Carroll	Sykesville	1☒Yes 2☐No

10e. Street and Number	10f. Zip Code	10g. Citizen of Whet Country?
7216 Springfield Avenue	21784	USA

11. Marital Status	12. Wes Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Ricen, etc.)	14. Rece - American Indian, Bleck, White, etc.
1☐Never Married 2☐Married 3☒Widowed 4☐Divorced	1☐Yes 2☒No If Yes, Give Yeer or Datas:	1☐Yes 2☒No Specify:	Specify: white

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usuel Occupetion (Give kind of work done during most of working lifa. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
	2	executive secretary	Wm F Zeller Co.

17. Fathar's Nama (First, Middle, Last)	18. Mother's Neme (First, Middle, Maiden Surname)
Fred C. Ackerly	Florence Stout

19a. Informent's Name/Reletionship (Type, Print)	19b. Mailing Addrass (Street end Number or Rural Routa Number, City or Town, State, Zip Code)
Donna Gardner Crismer (daughter)	7216 Springfield Ave, Sykesville, Md 21784

20a. Mathod of Disposition	20b. Place of Disposition (Name of cemetery, cramatory or other place)	Dete	20c. Location - City or Town, State
1☒Burial 2☐Cramation 3☐Ramoval from Stata 4☐Donation 5☐Othar (Specify)	Crest Lawn Memorial	3-21-01	Marriottsville, Md

21. Signeture of Funerel Service Licensee	22. Nama and Addrass of Facility
▶ Paige Haight Herbert	Haight Funeral Home & Chapel P.O. Box 195 Sykesville, Md 21784

Physician /Medical Examiner

23a. Part1. Entar tha disaasa, or complicetions thet ceused tha daath. Do not enter the mode of dying, such es cerdiec or respiratory errest, shock, or heert failure. List only one ceuse on eech line.

Approximete Interval Between Onset end Death

Immediete Causa (Finel disaasa or condition resulting in death)

a. Senile Dementia, Alzheimers type — 3 yeArs

Sequentially list conditions, if any, leeding to immediete ceuse. Entar Undarlying Cause (Diseese or injury that initiated avants resulting in death) Last

b. Due to (or es e consequanca of):

c. Due to (or es e consequance of):

d. Due to (or es e consequance of):

tF FEMALE: 23b. Was decedant pregnant in tha past 12 months?	23c. If yas, outcome of pregnency	23d. Dete of delivery
1☐Yes 2☒No 9☐Unknown	1☐Live birth 2☐Fetel deeth 3☐Ectopic pregnancy 4☐Pregnant at time of daath 5☐Othar (specify) _____ 9☐Unknown	Month Day Year

Part II. **Dther significant conditions** contributing to death but not resulting in the underlying cause grvan in Part I.

23e. Did tobecco use contribute to the cause of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

24a. Was an autopsy performed?	24b. Were eutopsy findings available prior to completion of cause of death?
1☐Yes 2☒No	1☐Yes 2☐No

25. Was case referred to medical examinar?	26. Place of Death (Check only one)	
1☐Yes 2☒No	Hospital: 1☐Inpatiant 2☐ER/Outpatient 3☐DOA	Othar: 4☐Nursing Home 5☒Residence 8☐Other (Specify)

27. Mennar of Daath	28a. Deta of Injury (Month, Day Yaar)	28b. Time of Injury	28c. Injury at Work?	28d. Dascribe how injury occurred
1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Panding investigetion 6☐Could not be datarmined		M	1☐Yes 2☐No	

28e. Place of Injury - At homa, farm, straat, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Numbar, City or Town, State)

29a. Certifier (Check only one) 1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, end dua to tha cause(s) and menner as stated. 2☐**Medicat Examiner:** On tha basis of examination and/or investigation, in my opinion, death occurred et tha time, date end place, end due to the cause(s) end manner stated.

29b. Signature and title of certifier	29c. Licensa number	29d. Date signed (Month, Day, Yeer)
▶ Thomas H. Galvin III	D31660	3/19/2001

30. Nama and address of person who completed causa of daeth (Item 23a) (Type, Print)
THOMAS GALVIN III MD 291 STONER AVE. WESTMINSTER, MD 21157

State Registrar

31. Date filed (Month, Day, Yaar)	32. Registrar's Signature
MAR 2 0 2001	▶ Brenda G Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 end 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Medical Certification; To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

WJR 4

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 10191

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Maurice Harry Gosnell

2. Date of Death (Month, Day, Year): March 15, 2001

3. Time of Death: 1:00 am M

4a. Facility Name (If not institution, give street and number): Carroll County General Hospital

4b. City, Town, or Location of Death: Westminster

4c. County of Death: Carroll

Funeral Director

5. Social Security Number: 219-20-4256

6. Sex: 1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday): 95 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Mar 7, 1906

9. Birthplace (State or Foreign Country): Maryland

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: Maryland

10b. County: Carroll

10c. City, Town or Location: Hampstead

10d. Inside City Limits: 1 ☐ Yes 2 ☒ No

10e. Street and Number: 4014 Dana Court

10f. Zip Code: 21074

10g. Citizen of What Country? USA

11. Marital Status: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: white

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 11

College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Self Employed Contractor

18b. Kind of Business/Industry: Plumbing & Heating

17. Father's Name (First, Middle, Last): Joseph Harry Gosnell

18. Mother's Name (First, Middle, Maiden Surname): Tillie G. Hauff

19a. Informant's Name/Relationship (Type, Print): Jeanne Dansereau, daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 12250 90th Ave North, Seminole, FL 33772

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Hampstead Cemetery

Date: 3/19/2001

20c. Location - City or Town, State: Hampstead, MD

21. Signature of Funeral Service Licensee: ▶ Steven Weime M00723

22. Name and Address of Facility: Eline Funeral Home 934 South Main St, Hampstead, MD 21074

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Pneumonia

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediete cause. Enter Underlying Cause (Disease or injury thet initiated events resulting in death) Last

b. Dementia

Due to (or as a consequence of):

c. CVA

Due to (or as e consequence of):

d. CAD

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown

23c. If yes, outcome of pregnancy: 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnency 4 ☐ Pregnent at time of death 5 ☐ Other (specify) 9 ☐ Unknown

23d. Date of delivery: Month Dey Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Dehydration
Depression

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification; To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1 ☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ RM Ramana MD

29c. License number: D-0054218

29d. Date signed (Month, Day, Year): 03-15-01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): DR. Raman B. Kanena 419-F Malcolm drive, West minster MD 21157

WJS 5 6

State Registrar

31. Date filed (Month, Day, Year): MAR 2 0 2001

32. Registrar's Signature: ▶ Geneva B Sparks

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23e or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

ADMEND ITEM: #23 PART I PER PHY G794 4-2-01 WR

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 10192

Gloria German

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Gloria, German
2. Date of Death (Month, Day, Year): February 10 2001
3. Time of Death: 11:55 a.m.
4a. Facility Name (If not institution, give street and number): Wicomcio Nursing Home
4b. City, Town, or Location of Death: Salisbury
4c. County of Death: Wicomico

Funeral Director

5. Social Security Number: 083-18-1464
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 76 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): July 16, 1924
9. Birthplace (State or Foreign Country): Massachusetts

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: Maryland
10b. County: Wicomico
10c. City, Town or Location: Delmar
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 8811 Shell Road
10f. Zip Code: 21875
10g. Citizen of What Country? USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 11 | College (1-4or 5+): —
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker
16b. Kind of Business/Industry: Domestic

17. Father's Name (First, Middle, Last): Unknown
18. Mother's Name (First, Middle, Maiden Surname): Unknown

19a. Informant's Name/Relationship (Type, Print): Ronald German/Husband
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 8811 Shell Rd., Delmar, MD 21875

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Parsons Cemetery
Date: 2/13/01
20c. Location - City or Town, State: Salisbury, MD

21. Signature of Funeral Service Licensee: ▶ Keith R Lowe CFSP
22. Name and Address of Facility: Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. ~~ASPIRATION~~ PNEUMONIA — 6-8 HOURS

Due to (or as a consequence of):
b. ~~CHRONIC PANCREATITIS~~ — MONTHS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
ALZHEMER'S DEMENTIA
HYPERTENSION

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☑ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

29a. Certifier (Check one): ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. ☑ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and Title of certifier: ▶ MOHAN BHAT, MD
29c. License number: D0055006
29d. Date signed (Month, Day, Year): FEBRUARY 13, 2001
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): 614-B EASTERN SHORE DRIVE, SALISBURY, MD 21804

State Registrar

31. Date filed (Month, Day, Year): FEB 15 2001
32. Registrar's Signature: Geneva G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Amended # 26
ACHO 3/27/01 MLV

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 10193

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: JOSEPH E. GULICK
2. Date of Death Month Day Year: March 21, 2001
3. Time of Death: 1627
4a. Facility Name *(If not institution, give street and number)*: 11215 DEHAVEN ROAD, N.E.
4b. City, Town, or Location of Death: CUMBERLAND
4c. County of Death: ALLEGANY

Funeral Director

5. Social Security Number: 219-44-2214
6. Sex: 1☐ M 2☐ F — X
7. Age *(in yrs. last birthday)*: 54 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: AUG. 29, 1946
9. Birthplace *(State or Foreign Country)*: MARYLAND

Usual Residence of Decedent

10a. State: MD
10b. County: ALLEGANY
10c. City, Town or Location: CUMBERLAND
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 11215 DEHAVEN ROAD, N.E.
10f. Zip Code: 21502
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married — X — 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☒ Yes 2☐ No — If Yes, Give Year or Dates: '64-'68
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No — X — Specify:
14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): — College (1-4or 5+): 2
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: SELF-EMPLOYED
16b. Kind of Business/Industry: FINE WOODWORKING

17. Father's Name *(First, Middle, Last)*: WILLIAM E. GULICK, SR.
18. Mother's Name *(First, Middle, Maiden Surname)*: PHYLLIS C. DEHAVEN

19a. Informant's Name/Relationship *(Type, Print)*: MARYANN (BOSKA) GULICK/WIFE
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 11215 DEHAVEN ROAD, N.E.,CUMBERLAND, MD 21502

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State — X — 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: ROSE HILL CEMETERY
Date: 03/26/2001
20c. Location - City or Town, State: HAGERSTOWN, MD

21. Signature of Funeral Service Licensee: Debra D. Upchurch
22. Name and Address of Facility: UPCHURCH FUNERAL HOME,P.A. 202 GREENE ST., CUMBERLAND, MD 21502

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Bronchogenic Carcinoma — 15 months
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☒ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☒ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☒ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Richard D. Schmitt M.D.
29c. License number: D26333
29d. Date signed *(Month, Day, Year)*: 3/23/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Richard Schmitt, M.D. 900 Seton Ct. - Cumberland, Md 21502

State Registrar

31. Date filed *(Month, Day, Year)*: MAR 26 2001
32. Registrar's Signature: Bonnie D Sparks

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important:** If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

11
MLS

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 10194

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): BONNIE MAY HANNAH

2. Date of Death (Month, Day, Year): March 16 2001

3. Time of Death: 1:40 AM

4a. Facility Name (If not institution, give street and number): Citizens Nursing Home

4b. City, Town, or Location of Death: Havre de Grace

4c. County of Death: Harford

Funeral Director

5. Social Security Number: 217-50-5635

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 87 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Apr. 25, 1913

9. Birthplace (State or Foreign Country): N. Carolina

Usual Residence of Decedent

10a. State: N.C.

10b. County: Henderson

10c. City, Town or Location: Hendersonville

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: RD 6, Box 261 D

10f. Zip Code: 28792

10g. Citizen of What Country? USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 5 College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker

16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): G. W. Messer

18. Mother's Name (First, Middle, Maiden Surname): Rachel (u/k) Bright

19a. Informant's Name/Relationship (Type, Print): Arlo Hannah - Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): RD 6, Box 261 D, Hendersonville, NC 28792

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Bel Air Memorial Grdns.

Date: 3/19/01

20c. Location - City or Town, State: Bel Air, Maryland

21. Signature of Funeral Service Licensee: Stephen A. Hughes

22. Name and Address of Facility: McComas Funeral Home, P.A. 1317 Cokesbury Rd., Abingdon, MD 21009

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Acute congestive heart failure — 3 days

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Diabetes Mellitus Type II
Dementia
Polyarthritis
Anemia

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 8☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated.

29b. Signature and title of certifier: Mirza A. Baig MD

29c. License number: D43115

29d. Date signed (Month, Day, Year): 3-16-01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): 615 S. Union Ave, Havre de Grace MD 21078

State Registrar

31. Date filed (Month, Day, Year): MAR 19 2001

32. Registrar's Signature: Donna B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Hannah, Bonnie M.

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

2001 10195
Reg. No.

Amend Item #26, Per Phy. 3-20-01 HCHD LM

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
Amanda Miltilda Hungerford	March 19, 2001	5:00 AM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
315 Giles Street	Havre de Grace	Harford

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
212-32-9709	1☐ M 2☒ F	100 Yrs.			Dec. 26, 1900	Nebraska

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Harford	Havre de Grace	1☒ Yes 2☐ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
315 Giles Street	21078	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced	1☐ Yes 2☒ No If Yes, Give Year or Dates:	1☐ Yes 2☒ No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
8		Homemaker	Own Home

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Albert Emil Redmer	Martha (u/k) Fleischman

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Gloria R. Cannizzaro / Daughter	315 Giles St., Havre de Grace, Maryland 21078

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)	Moreland Memorial Park Cem.	3-22-01	Baltimore, Maryland

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ Stake A. Hugh	McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. respiratory failure	< 2 weeks
Due to (or as a consequence of):		
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. end stage cardiac disease	
Due to (or as a consequence of):		
	c.	
Due to (or as a consequence of):		
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. **Did tobacco use contribute to the cause of death?** 1☐ **Yes** 2☒ **No** 3☐ **Probably** 4☐ **Unknown**

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐ Yes 2☒ No	1☐ Yes 2☒ No

25. Was case referred to medical examiner?	28. Place of Death (Check only one)
1☐ Yes 2☒ No	Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: ~~4☒ Nursing Home~~ 5☒ Residence 8☐ Other (Specify)

27. Manner of Death	28e. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined		M	1☐ Yes 2☐ No	
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ David S. Dunn	D32279	March 19, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
DAVID S. DUNN (15 W. MacPha.)

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
MAR 20 2001	Donna B. Sparks

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

LM

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DHMH 16 Rev 6/95

CPS
01-1568-017
MARVIN HENDERSON

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

1- For State Registrar

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 10196

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
Marvin Horace Henderson Sr.	March 20, 2001	2:57 PM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Route 231 and Farm Place	Hughesville	Charles

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
219-12-2692	1☒ M 2☐ F	72 Yrs.			June 2, 1928	Maryland

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Prince Georges	Upper Marlboro	1☒ Yes 2☐ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
8010 Croom Station Road	20772	U.S.A.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced	1☐ Yes 2☐ No If Yes, Give Year or Dates: 1950-1951	1☐ Yes 2☒ No Specify:	Specify: Black

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12		Skilled Labor	Kirk Lindsey Concrete Construction Co.

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Ernest Henderson	Laura Clark

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Elizabeth Henderson/ Wife	8010 Croom Station Rd Upper Marlboro MD 20772

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)	Resurrection Cem.	03/27/01	Clinton, Maryland

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
191	Adams Funeral Home P.A. Aquasco, Maryland

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Multiple Injuries

Due to (or as a consequence of):
b.

Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1☐ Yes 2☐ No 9☐ Unknown	23c. If yes, outcome of pregnancy 1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) 9☐ Unknown	23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☒ Yes 2☐ No	1☒ Yes 2☐ No

Medical Certification; To Be Completed by Physician/Medical Examiner

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☒ Yes 2☐ No	Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA	Other: 4☐ Nursing Home 5☐ Residence 8☒ Other (Specify) SCENE

27. Manner of Death	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☐ Natural 2☒ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined	3/20/01	2:51PM	1☐ Yes 2☒ No	Driver of Motor Vehicle Collides with Another Vehicle

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)
Street	Hughesville Maryland

29a. Certifier (Check only one)
1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☒ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
J Pestaner M.D.	OCME	March 21, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Joseph Pestaner 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
MAR 26 2001	B. Sparks

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 10197

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Ada Winfrey Hufton

2. Data of Death: Month March Day 18 Year 2001

3. Time of Death: 9:15 am.

4a. Facility Name (If not institution, give street and number): Long View Nursing Home

4b. City, Town, or Location of Death: Manchester

4c. County of Death: Carroll

Funeral Director

5. Social Security Number: 327-42-9494

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 93 Yrs.

If Under 1 Year: Months ____ Days ____

If Under 24 Hrs.: Hours ____ Min. ____

8. Data of Birth (Month, Day, Year): March 3, 1908

9. Birthplace (State or Foreign Country): Kansas

Usual Residence of Decedent

10a. State: Maryland

10b. County: Carroll

10c. City, Town or Location: Westminster

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 3846 Turkeyfoot Rd.

10f. Zip Code: 21158

10g. Citizen of What Country? U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yas, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 12

College (1-4or 5+): 2

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Housewife

16b. Kind of Business/Industry: Homemaker

17. Father's Name (First, Middle, Last): Rev. Frank Winfrey

18. Mother's Name (First, Middle, Maiden Surname): Alice Meier

19a. Informant's Name/Relationship (Type, Print): Jack Winfrey - nephew

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3846 Turkeyfoot Rd. Westminster, Md. 21158

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Manchester Baptist Ch. Cem.

Date: March 21, 2001

20c. Location - City or Town, State: Manchester, Md.

21. Signature of Funeral Service Licensee: ▶ J. Hal Eckhardt

22. Name and Address of Facility: Eckhardt Funeral Chapel P.A. 3296 Charmil Dr. Manchester, Md. 21102

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. CVA — 3wk

Due to (or as a consequence of):

b. ASCVD — 20y

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c. advanced age — 93y

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one)

Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA

Other: 4☒ Nursing Home 5☐ Residence 8☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: John Middleton

29c. License number: D25443

29d. Date signed (Month, Day, Year): 3-19-2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): John W. Middleton 688 Poole Road, Westminster MD 21157

State Registrar

31. Data filed (Month, Day, Year): MAR 19 2001

32. Registrar's Signature: ▶ D Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 28a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

CEW 6

01-1667-033
mnmr
Becky J. Hynck

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar AMEND ITEM 1,23a,27,28a-f per ME 051601 SS

Certificate of Death

Reg. No. 2001 10198

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)			2. Date of Death Month Day Year	3. Time of Death
~~Rebecca~~ Becky	Jean Costello	Hynek	March 25, 2001	1110 a M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Prince George's Hospital Center	Cheverly	Prince George's

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year Months	If Under 1 Year Days	If Under 24 Hrs. Hours	If Under 24 Hrs. Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
483-54-4445	1☐M 2☒F	54 Yrs.					Sept. 20,1946	Iowa

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
D.C.	N/A	Washington D.C.	1☒Yes 2☐No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
3225 T Street S.E.	20020	U.S.A.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐Never Married 2☒Married 3☐Widowed 4☐Divorced	1☐Yes 2☒No If Yes, Give Year or Dates:	1☐Yes 2☒No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementery/Secondary (0-12)	College (1-4or 5+)		
12th	2	Staffing Specialist	Library of Congress

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Meiden Sumame)
James V. Costello, II	Ruth G. Goid

19a. Informant's Name/Reletionship (Type, Print)	19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code)
Frank Hynek (Husband)	3225 T Street S.E. Washington D.C. 20020

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, cremetory or other place)	Date	20c. Location - City or Town, State
1☐Burial 2☒Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	Lee Crematory	March 28, 2001	Clinton, Maryland

21. Signature of Funeral Service Licensee ▶ [signature]

22. Name and Address of Facility Lee Funeral Home, Inc. 6633 Old Alexandria Ferry Road Clinton, MD20735

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Finel disease or condition resulting in death)

a. CARDIAC ARRHYTHMIA COMPLICATED BY HEAD INJURIES

Due to (or as a consequenca of):

Sequentially list conditions, if any, leading to immediete cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month Day Year
1☐Yes 2☒No 9☐Unknown	1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnent at time of death 5☐Other (specify) 9☐Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause ot deeth? 1☐Yes 2☐No 3☐Probably 4☐Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☒Yas 2☐No	1☒Yes 2☐No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☒Yas 2☐No	Hospital: 1☐Inpatient 2☒ER/Outpatient 3☐DOA	Other: 4☐Nursing Home 5☐Residenca 8☐Other (Specify)

27. Manner of Death	28a. Dete of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☐Natural 2☒Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined	3-24-01	11 P M	1☐Yes 2☒No	subject fell down stairs

28e. Place of Injury - At home, farm, street, factory, offica building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)
home	3225 T St.,SE, Washington, DC

Medical Certification; To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one) 1☐Certifying Phyaicfan: To the best of my knowledge, death occurred at the time, date and placa, and due to the cause(s) end manner es stated. 2☒Medical Examfner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date and place, end due to the cause(s) end manner stated.

29b. Signature and title of certifier	29c. Licanse number	29d. Date signed (Month, Day, Year)
▶ [signature] MD	O.C.M.E.	March 26, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
J. Allan Locke, MD 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
APR 0 3 2001	▶ [signature]

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 10199

Hess, Evelyn M

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

4

7/28

Physician /Medical Examiner — **Funeral Director** — **To Be Completed by Funeral Director**

1. Decedent's Name (First, Middle, Last): Evelyn May Hess
2. Date of Death: Month March Day 19 Year 2001
3. Time of Death: 18:20
4a. Facility Name (If not Institution, give street and number): Lions Manor Nursing Home
4b. City, Town, or Location of Death: Cumberland
4c. County of Death: Allegany
5. Social Security Number: 220-10-4155
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 85 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Mar 11, 1916
9. Birthplace (State or Foreign Country): WV

Usual Residence of Decedent

10a. State: MD
10b. County: Allegany
10c. City, Town or Location: Cumberland
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: Old Towne Manor Apts
10f. Zip Code: 21502
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No — If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: white

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 — College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): nurses aid
16b. Kind of Business/Industry: Memorial Hospital

17. Father's Name (First, Middle, Last): John Wesley Clingerman
18. Mother's Name (First, Middle, Maiden Surname): Mary E (Chaney)

19a. Informant's Name/Relationship (Type, Print): Harry Hess son
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 12524 Marlow Road;Fulton MD 20759

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Hillcrest Memorial Par2001
Date: 3/22/
20c. Location - City or Town, State: Cumberland, MD

21. Signature of Funeral Service Licensee: ▶ Nicholas J. Scarpelli
22. Name and Address of Facility: Scarpelli Funeral Home, P.A. Cumberland, MD 21502

Physician /Medical Examiner — **Medical Certification: To Be Completed by Physician/Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Septicemia	1 wk
	Due to (or as a consequence of):	
	b. U.T.I	1 wk
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of):	
	c.	
	Due to (or as a consequence of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Senility, Collagen vascular disease dementia, C.H.F, interstitial fibrosis

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☒ Nursing Home 5☐ Residence 8☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day, Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ V.A. Ranjithan MD
29c. License number: D19750
29d. Date signed (Month, Day, Year): March 20, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): V.A. Ranjithan MD Lions Manor Nursing Home, Seton Drive Extended, Cumberland MD 21502

State Registrar

31. Date Filed (Month, Day, Year): MAR 21 2001
32. Registrar's Signature: ▶ Joyce D Sparks

DHMH 16 Rev 6/95

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 10200

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): ANNA MARIE HARDY
2. Date of Death: Month MARCH, Day 20, Year 2001
3. Time of Death: 7:35 AM
4a. Facility Name (If not institution, give street and number): ST. VINCENT DEPAUL NURSING CENTER
4b. City, Town, or Location of Death: FROSTBURG
4c. County of Death: ALLEGANY

Funeral Director

5. Social Security Number: 220-30-8248
6. Sex: 1☐M 2☒F
7. Age (If yrs. last birthday): 66 Yrs. | If Under 1 Year: Months, Days | If Under 24 Hrs.: Hours, Min.
8. Date of Birth (Month, Day, Year): Jul 20, 1934
9. Birthplace (State or Foreign Country): MD

Usual Residence of Decedent

10a. State: WV
10b. County: Mineral
10c. City, Town or Location: Wiley Ford
10d. Inside City Limits: 1☐Yes 2☒No
10e. Street and Number: P.O. Box 314
10f. Zip Code: 26767
10g. Citizen of What Country?: USA

11. Marital Status: 1☐Never Married 2☐Married 3☒Widowed 4☐Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐Yes 2☒No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No Specify:
14. Race - American Indian, Black, White, etc. Specify: white

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker
16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): Thomas G. Smith, Sr.
18. Mother's Name (First, Middle, Maiden Surname): Mary E (House)

19a. Informant's Name/Relationship (Type, Print): David Hardy son
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): P.O. Box 314;Wiley Ford WV 26767

20a. Method of Disposition: 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)
20b. Place of Disposition (Name of cemetery, cremetory or other place): Restlawn Memorial Gard
Date: 3/23/2001
20c. Location - City or Town, State: LaVale, MD

21. Signature of Funeral Service Licensee: Nicholas J. Scarpelli
22. Name and Address of Facility: Scarpelli Funeral Home, P.A. Cumberland, MD 21502

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Progressive Azotemia — 1 mo.
Due to (or as a consequence of):
b. Renal failure
Due to (or as a consequence of):
Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
c. Diabetic Nephropathy
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Congestive Heart failure

23b. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☒Unknown

24a. Was an autopsy performed? 1☐Yes 2☒No
24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☒No

25. Was case referred to medical examiner? 1☐Yes 2☒No

26. Place of Death (Check only one): Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☒Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death: 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐Yes 2☐No
28d. Describe how injury occurred
28e. Piece of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) and manner es stated. 2☐Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Wonsock Shin MD
29c. Licensa number: D0055325
29d. Date signed (Month, Day, Year): March 20, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): WONSOCK SHIN 48 Town Terrace Suite 204 Frostburg, MD 21532

State Registrar

31. Date filed (Month, Day, Year): MAR 21 2001
32. Registrar's Signature: Geneva G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 10201

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Lalla R. Hansford

2. Date of Death (Month, Day, Year): Mar 21, 2001

3. Time of Death: 03:30am

4a. Facility Name (If not institution, give street and number): Cumberland Nursing Home

4b. City, Town, or Location of Death: Cumberland

4c. County of Death: Allegany

Funeral Director

5. Social Security Number: 212-76-0435

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 85 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Mar 24, 1915

9. Birthplace (State or Foreign Country): MD

Usual Residence of Decedent

10a. State: MD

10b. County: Allegany

10c. City, Town or Location: Cumberland

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 100 Arch Street

10f. Zip Code: 21502

10g. Citizen of What Country: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexicen, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: white

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): homemaker

16b. Kind of Business/Industry: own home

17. Father's Name (First, Middle, Last): George Wesley Sciese

18. Mother's Name (First, Middle, Maiden Surname): Bessie R (Pryor)

19a. Informant's Name/Relationship (Type, Print): Dorothy Stonebreaker daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 41 Race Street; Cumberland, MD21502

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, cremetory or other place): Restlawn Memorial Gard

Date: 3/23/2001

20c. Location - City or Town, State: LaVale, MD

21. Signature of Funeral Service Licensee: James J Scarpelli

22. Name and Address of Facility: Scarpelli Funeral Home P.A. Cumberland, Maryland 21502

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiretory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediete Cause (Finel disease or condition resulting in death)	a. Aspiration Pneumonitis	12 hrs
	Due to (or as a consequence of):	
	b. CVA	2 week
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of):	
	c.	
	Due to (or as a consequence of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Netural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or Investigetion, In my opinion, deeth occurred at the time, date end place, snd due to the cause(s) and manner stated.

29b. Signature and title of certifier: Huma Shakil MD

29c. License number: D46346

29d. Date signed (Month, Day, Year): MAR. 22. 2001

30. Name and address of person who completed ceuse of death (Item 23a) (Type, Print): Huma Shakil M.D. 625 Kent Avenue Suite 304 Cumberland MD 21502

State Registrar

31. Date filed (Month, Dey, Year): MAR 22 2001

32. Registrar's Signature: Donna B Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 10202

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Nettie Elizabeth Insley
2. Date of Death Month Day Year: March 16, 2001
3. Time of Death: 2:40 PM
4a. Facility Name (If not institution, give street and number): 609 Long Bar Harbor Road
4b. City, Town, or Location of Death: Abingdon
4c. County of Death: Harford

Funeral Director

5. Social Security Number: 215-34-5909
6. Sex: 1☐ M 2☒ F
7. Age (in yrs. last birthday): 64 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Mar. 28, 1936
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Harford
10c. City, Town or Location: Abingdon
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 609 Long Bar Harbor Road
10f. Zip Code: 21009
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White
15. Decedent's Education (Specify only highest grade completed): Elementery/Secondary (0-12): / College (1-4or 5+): 2
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Chief of DRMO
16b. Kind of Business/Industry: U.S. Government
17. Father's Name (First, Middle, Last): Leonard (u/k) Stearn
18. Mother's Name (First, Middle, Maiden Surname): Annie Mae Hughes
19a. Informant's Name/Relationship (Type, Print): Thomas M. Insley, Sr. / Husband
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 609 Long Bar Harbor Rd., Abingdon, MD 21009
20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Harford Memorial Gardens
Date: 3-19-01
20c. Location - City or Town, State: Aldino, Maryland
21. Signature of Funeral Service Licensee: Kelly McComas Reinsfo
22. Name and Address of Facility: McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, MD 21009

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. (Approximate Interval Between Onset and Death)

Immediate Cause (Final disease or condition resulting in death): a. Metastatic Carcinoma to Lung.
Due to (or as a consequence of): b. Carcinoma of the Vulva
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
Due to (or as a consequence of): c.
Due to (or as a consequence of): d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Congestive heart failure; Massive pleural Effusion

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)
27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: George L. Henry M.D.
29c. License number: DO 6547
29d. Date signed (Month, Day, Year): 3/19/2001
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): GEORGE L. HENRY M.D. 601 S. Union Ave Havre DeGrace Md

State Registrar

31. Date filed (Month, Day, Year): MAR 20 2001
32. Registrar's Signature: D. Sparks

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 10203

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
RALPH LOUIS JONES	March 16, 2001	2346 P M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
SACRED HEART HOSPITAL	CUMBERLAND	ALLEGANY

Funeral Director

5. Social Security Number	8. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
219-14-5782	1 M X 2 F	76 Yrs.			Mar. 31, 1924	MARYLAND

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	ALLEGANY	CUMBERLAND	1 X Yes 2 No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
212 WALLACE STREET	21502	U.S.A.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1 Never Married 2 X Married 3 Widowed 4 Divorced	1 X Yes 2 No If Yes, Give Year or Dates: WWII	1 Yes 2 X No Specify:	Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	18b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12		SHIPPING CLERK	RETAIL STORE

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
JAMES EDWARD JONES	OPAL FREEDMAN

19e. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
LOUIS A. JONES / SON	226 PACA STREET, CUMBERLAND, MD 21502

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)	M.S.V.C.-ROCKY GAP	03/20/2001	FLINTSTONE, MD

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ Gerry A. Upchurch	UPCHURCH FUNERAL HOME, P.A. 202 GREENE STREET, CUMBERLAND, MD 21502

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. MYOCARDIAL INFARCTION	1 hour
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE Due to (or as a consequence of):	20 years
	c. Due to (or as a consequence of):	
	d. Due to (or as a consequence of):	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month Day Year
1 Yes 2 No 9 Unknown	1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify) 9 Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?	24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1 Yes 2 ✓ No 3 Probably 4 Unknown	1 Yes 2 ✓ No	1 Yes 2 No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1 ✓ Yes 2 No	Hospital: 1 Inpatient 2 ✓ ER/Outpatient 3 DOA	Other: 4 Nursing Home 5 Residence 6 Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1 ✓ Natural 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined		M	1 Yes 2 No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification; To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one) 1 **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ Donald Manger MD OME	DO 9231	March 17 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
DONALD MANGER 11600 Bedford Road Cumberland MD 21502

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
MAR 20 2001	Jessica G Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23e or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

1- For State Registrar

Reg. No. 2001 10204

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)			2. Date of Death Month	Day	Year	3. Time of Death
CHANDRALECA	J.	KARAPURKAR	March	16	200	1201 AM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Upper Chesapeake Medical Center	Bel Air	Harford

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months	Days	If Under 24 Hrs.: Hours	Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
131-60-9576	1☐M 2☒F	48 Yrs.					Mar. 24, 1952	Goa India

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Harford	Bel Air	1☐Yes 2☒No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
1704 Magnum Court	21015	India

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐Never Married 2☒Married 3☐Widowed 4☐Divorced	1☐Yes 2☒No If Yes, Give Year or Dates:	1☐Yes 2☒No Specify:	Specify: Indian

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
	2	Homemaker	Own Home

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Balaji (nmn) Kamat	Sunita (nmn) U/K

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Jayant Y. Karapurkar - Husband	1704 Magnum Court, Bel Air, Maryland 21015

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☐Burial 2☒Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	Hilltop Service Corp.	03/17/01	Towson, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility: McComas Funeral Home, P.A. 1317 Cokesbury Rd., Abingdon, MD 21009

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiec or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) a.	Carcinoma Right Breast	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last: Due to (or as a consequence of): b.	Metastasis to Brain and Spine	2yrs
Due to (or as a consequence of): c.		
Due to (or as a consequence of): d.		

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month Day Year
1☐Yes 2☐No 9☐Unknown	1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Sacral Decubetus ulcer

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐Yes 2☒No	1☐Yes 2☐No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐Yes 2☒No	Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA	Other: 4☐Nursing Home 5☐Residence 8☐Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined		M	1☐Yes 2☐No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
	D18424	March-16-2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): B. Pavekh M.D. 1907 Harford Rd. Fallston MD. 21047.

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
MAR 19 2001	

DHMH 17 Rev 1/2001

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

KARAPURKAR CHANDRALECA

AM

2

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No: 2001 10205

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): John David Kenney

2. Date of Death: Month March Day 20 Year 2001

3. Time of Death: 0736

4a. Facility Name (If not institution, give street and number): PENINSULA REGIONAL MEDICAL CENTER

4b. City, Town, or Location of Death: SALISBURY

4c. County of Death: WICOMICO

Funeral Director

5. Social Security Number: 055-28-8719

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 63 Yrs.

If Under 1 Year: Months Days

If Under 24 Hrs.: Hours Min.

8. Date of Birth (Month, Day, Year): May 17, 1937

9. Birthplace (State or Foreign Country): New York

Usual Residence of Decedent

10a. State: MD

10b. County: Wicomico

10c. City, Town or Location: Salisbury

10d. Inside City Limits: 1 [X] Yes 2 [ ] No

10e. Street and Number: 204 Woodcrest Avenue

10f. Zip Code: 21804

10g. Citizen of What Country: USA

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 12

College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Salesman

16b. Kind of Business/Industry: Hotels

17. Father's Name (First, Middle, Last): Clossie Kenney

18. Mother's Name (First, Middle, Maiden Surname): Mary Louise Piche

19a. Informant's Name/Relationship (Type, Print): Bonnie Kenney /Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 213 Glen Ave. Salisbury, MD 21804

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Cambridge Crematory

Date: 3-21-01

20c. Location - City or Town, State: Cambridge, Maryland

21. Signature of Funeral Service Licensee: Melissa Kay Haney

22. Name and Address of Facility: Bounds Funeral Home 705 E. Main St. Salisbury, MD 21804

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Aspiration Pneumonia

Due to (or as a consequence of):

CVA

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

DM 2

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one)

Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA

Other: 4 [ ] Nursing Home 5 [ ] Residence 8 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number: H54827

29d. Date signed (Month, Day, Year): 3/21/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Marcella Gilliland 100 Milford St Suite 201 Salisbury MD 21804

State Registrar

31. Date filed (Month, Day, Year): MAR 21 2001

32. Registrar's Signature: Denise G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If Item 27 is marked other than "natural", or Items 28a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

John Kenney

2+IVA DQ

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 10206

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Martin Luther Kipe
2. Date of Death: Month Mar, Day 16, Year 2001
3. Time of Death: 8:45pm
4a. Facility Name (If not institution, give street and number): 16 Leppo Road
4b. City, Town, or Location of Death: Westminster
4c. County of Death: Carroll

Funeral Director

5. Social Security Number: 215-26-1197
6. Sex: 1 ☒ M 2 ☐ F
7. Age (In yrs. last birthday): 72 Yrs. | If Under 1 Year: Months, Days | If Under 24 Hrs.: Hours, Min.
8. Date of Birth (Month, Day, Year): Dec 16 1928
9. Birthplace (State or Foreign Country): MD

Usual Residence of Decedent

10a. State: MD
10b. County: Carroll
10c. City, Town or Location: Union Bridge
10d. Inside City Limits: 1 ☐ Yes 2 ☒ No
10e. Street and Number: 510 Clear Ridge Road
10f. Zip Code: 21791
10g. Citizen of What Country?: USA

11. Marital Status: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Assembly Specialist
16b. Kind of Business/Industry: Black and Decker

17. Father's Name (First, Middle, Last): Hiram W. Kipe Sr
18. Mother's Name (First, Middle, Maiden Surname): Annie Elizabeth Davis

19a. Informant's Name/Relationship (Type, Print): Robert Kipe/son
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 353 Old Bachmans Valley Rd Westminster, MD 21157

20a. Method of Disposition: ☒ 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Evergreen Memorial
Date: 3/20/2001
20c. Location - City or Town, State: Finksburg, MD

21. Signature of Funeral Service Licensee: John K. Apel
22. Name and Address of Facility: Fritts Funeral Home and Chapel, 412 Washington Rd Westminster, MD 21157

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death):
a. METASTATIC PANCREATIC CA

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting in death) Last:
b.

Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☑ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No
26. Place of Death (Check only one): Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA; Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☑ Other (Specify) FRIEND'S HOUSE

27. Manner of Death: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: Flavio Kruter MD
29c. License number: D35398
29d. Date signed (Month, Day, Year): 3-19-01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): 555 South Center St Westminster md 21157 FLAVIO KRUTER, M.D.

State Registrar

31. Date filed (Month, Day, Year): MAR 2 0 2001
32. Registrar's Signature: Geneva G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

WJL
10

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 10207

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): JOHN PAUL KENNEY
2. Date of Death (Month, Day, Year): MARCH 15 2001
3. Time of Death: 2115
4a. Facility Name (If not institution, give street and number): ST VINCENT DEPAUL NURSING CENTER
4b. City, Town, or Location of Death: FROSTBURG
4c. County of Death: ALLEGANY

Funeral Director

5. Social Security Number: 213 01 5918
6. Sex: 1☒ M 2☐ F
7. Age (in yrs. last birthday): 90 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): JUNE 24, 1910
9. Birthplace (State or Foreign Country): MARYLAND

Usual Residence of Decedent

10a. State: MARYLAND
10b. County: ALLEGANY
10c. City, Town or Location: FROSTBURG
10d. Inside City Limits: ☒ 1 Yes 2☐ No
10e. Street and Number: 263 W. MECHANIC STREET
10f. Zip Code: 21532
10g. Citizen of What Country?: U.S.

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☒ Yes 2☐ No If Yes, Give Year or Dates: WW II
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 8 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): SPINNING DEPARTMENT
16b. Kind of Business/Industry: CELANESE CORP.

17. Father's Name (First, Middle, Last): JAMES KENNEY
18. Mother's Name (First, Middle, Maiden Surname): MARY ELIZABETH COUNIHAN

19a. Informant's Name/Relationship (Type, Print): ELEANOR KENNEY / WIFE
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 263 W. MECHANIC ST., FROSTBURG, MD 21532

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): FROSTBURG MEMORIAL PARK | Date: 3/19/01
20c. Location - City or Town, State: Frostburg, MD

21. Signature of Funeral Service Licensee: Nicholas Sowers
22. Name and Address of Facility: SOWERS FUNERAL HOME, P.A. 60 W. MAIN ST., FROSTBURG, MD 21532

Physician /Medical Examiner

23e. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Advanced Dementia (Alzheimer's) — 2 mo.

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieled evants resulting in death) Last:
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Cardiomyopathy
Chronic obstructive Lung disease.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Wonsock Shin MD
29c. License number: D0055325
29d. Date signed (Month, Day, Year): Mar 16, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): WONSOCK SHIN
48 Town Terrace suit 204 Frostburg, MD 21532

State Registrar

31. Date filed (Month, Day, Year): MAR 21 2001
32. Registrar's Signature: Donna B Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 10208

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: GEORGE HAROLD KINSLEY SR.

2. Date of Death Month Day Year: MARCH 24 2001

3. Time of Death: 6:00 PM

4a. Facility Name *(If not institution, give street and number)*: DEVLIN MANOR NURSING HOME

4b. City, Town, or Location of Death: CUMBERLAND

4c. County of Death: ALLEGANY

Funeral Director

5. Social Security Number: 172-18-3989

6. Sex: 1 [X] M 2 [ ] F

7. Age *(In yrs. last birthday)*: 80 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: MARCH 21 1921

9. Birthplace *(State or Foreign Country)*: W.VA.

Usual Residence of Decedent

10a. State: MARYLAND

10b. County: ALLEGANY

10c. City, Town or Location: CUMBERLAND

10d. Inside City Limits: 1 [X] Yes 2 [ ] No

10e. Street and Number: 1 BALTIMORE STREET

10f. Zip Code: 21502

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: 1942-1943

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 [ ] Yes 2 [X] No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* WHITE

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 9 / College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: B&O RAILROAD

16b. Kind of Business/Industry: CONDUCTOR/RAILROAD

17. Father's Name *(First, Middle, Last)*: WILLIAM KINSLEY

18. Mother's Name *(First, Middle, Maiden Surname)*: LILLIE NICHOLSON

19a. Informent's Name/Relationship *(Type, Print)*: GEORGE KINSLEY SON

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 5355 NORTH SEYMOUR ROAD, FLUSHING MICHIGAN 48433

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: SUNSET CEMETERY

Date: MARCH 27 2001

20c. Location - City or Town, State: CUMBERLAND MARYLAND

21. Signature of Funeral Service Licensee: Dale L. Merritt

22. Name and Address of Facility: MERRITT-ADAMS FUNERAL HOME P.A. 404 DECATUR STREET CUMBERLAND MARYLAND

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart feilure. List only one cause on eech line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Dementia, Alzheimer type — months

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that Initiated events resulting In deeth) Last

b.

Due to (or as a consequenca of):

c.

Due to (or as a consequenca of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: COPD ; Dysphasia ; Urinary tract infection ; bladder outlet obstruction

23b. Did tobacco uss contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Wes an eutopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death *(Check only one)*: Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpetient 3 [ ] DOA Other: 4 [X] Nursing Home 5 [ ] Residenca 6 [ ] Other *(Specify)*

27. Menner of Death: 1 [X] Neturel 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigetion 6 [ ] Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end menner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred et the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: J Bollino M.D.

29c. License number: D 0017565

29d. Date signed *(Month, Day, Year)*: MARCH 24, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): DR. ANTHONY J. BOLLINO JR. 922 NATIONAL HIGHWAY LAVALE, MARYLAND 21502

State Registrar

31. Date filed *(Month, Day, Year)*: MAR 26 2001

32. Registrar's Signature:

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

10

MS

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 10209

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: ROBERT E. LEE Sr.

2. Date of Death Month / Day / Year: March 20 2001

3. Time of Death: 5:40 PM

4a. Facility Name *(If not institution, give street and number)*: 746 Farmington Road West

4b. City, Town, or Location of Death: Accokeek

4c. County of Death: Prince George's

Funeral Director

5. Social Security Number: 212 14 0505

6. Sex: 1 [X] M 2 [ ] F

7. Age *(In yrs. last birthday)*: 80 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: FEB 3 1921

9. Birthplace *(State or Foreign Country)*: Washington, DC

Usual Residence of Decedant

10a. State: Maryland

10b. County: Prince George's

10c. City, Town or Location: Accokeek

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 746 Farmington Road West

10f. Zip Code: 20607

10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Nevar Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Evar in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Datas: WW II

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 10 | College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use ratired)*: Data processing

16b. Kind of Business/Industry: US Government

17. Father's Name *(First, Middle, Last)*: George Lee

18. Mother's Name *(First, Middle, Maidan Surname)*: Georgia Smoot Lee

19a. Informant's Name/Relationship *(Type, Print)*: Robert E. Lee Jr. (son)

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 3124 Eutaw Forest Drive Waldorf, MD 20603

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*

20b. Place of Disposition *(Name of cemetary, cramatory or other place)*: Trinity Memorial Gardens

Date: 3-24-01

20c. Location - City or Town, State: Waldorf, MD

21. Signature of Funeral Service Licensee: John A. Eberwein 1006

22. Name and Address of Facility: Eberwein Funeral Services, 4433 White Pls. La. White Pls., MD 20695

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that ceused the death. Do not entar the mode of dying, such as cardiac or respiratory arrest, shock, or heart failura. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediata Causa (Final disease or condition resulting in death)	a. Metastatic colon cancer	2yrs.
	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disaase or Injury that initiated events resulting in death) Last	b.	
	Due to (or as a consequance of):	
	c.	
	Due to (or as a consequence of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yas 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yas 2 [X] No

26. Place of Death *(Check only one)*: Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | Other: 4 [ ] Nursing Home 5 [X] Residence 8 [ ] Othar *(Specify)*

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be datarmined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, atc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 [X] **Certifying Physician**: To the best of my knowledge, death occurred at tha tima, data and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the tima, date and place, and dua to tha cause(s) and manner stated.

29b. Signature and Title of Certifier: D. Haidak

29c. Licensa number: D- 17605

29d. Date signed *(Month, Day, Year)*: 3/21/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): D.J. HAIDAK MD CLINTON, MD

State Registrar

31. Data filed *(Month, Day, Year)*: MAR 23 2001

32. Registrar's Signature: B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 10210

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): HARRY K. MORNINGSTAR

2. Date of Death: Month March Day 15 Year 2001

3. Time of Death: 00:46 M

4a. Facility Name (If not institution, give street and number): Upper Chesapeake Med. Center

4b. City, Town, or Location of Death: Bel Air

4c. County of Death: Harford

Funeral Director

5. Social Security Number: 190-16-7527

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 81 Yrs.

If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): 12/8/1919

9. Birthplace (State or Foreign Country): Pennsylvania

Usual Residence of Decedent

10a. State: MD

10b. County: Harford

10c. City, Town or Location: Bel Air

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 2207 Byrnes Court. Apt. G

10f. Zip Code: 21015

10g. Citizen of What Country?: United States

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No. If Yes, Give Year or Dates: WW 2

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 8 — College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Civilian Gunner

18b. Kind of Business/Industry: Civil Service

17. Father's Name (First, Middle, Last): Carl E. Morningstar

18. Mother's Name (First, Middle, Maiden Surname): Pearl Ruth Smeltzer

19a. Informant's Name/Relationship (Type, Print): Estella V. Morningstar

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2207 Byrnes Court, Apt. G., Bel Air, MD

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Tabernacle Cem.

Date: 3/19/01

20c. Location - City or Town, State: Whiteford, MD

21. Signature of Funeral Service Licensee: Jeffrey P. Lovelace

22. Name and Address of Facility: Harkins Funeral Home, Inc., Delta, PA

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Myocardial Infarction — 2 weeks

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Artherosclerosis — 10 years

Due to (or as a consequence of):

c. Diabetes Mellitus — 15 years

Due to (or as a consequence of):

d.

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1 [ ] Yes 2 [ ] No 9 [ ] Unknown

23c. If yes, outcome of pregnancy: 1 [ ] Live birth 2 [ ] Fetal death 3 [ ] Ectopic pregnancy 4 [ ] Pregnant at time of death 5 [ ] Other (specify) 9 [ ] Unknown

23d. Date of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification; To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of *my* knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, end due to the cause(s) and manner stated.

29b. Signature and title of certifier: MD

29c. License number: D36715

29d. Date signed (Month, Day, Year): March 16, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Sherif Osman, Md 39 Churchville Rd Forest Hill, MD 21050

State Registrar

31. Date filed (Month, Day, Year): MAR 19 2001

32. Registrar's Signature: G. Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

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To Be Completed by Funeral Director

Harry K. Morningstar MD

9+1

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 10211

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Alexander S. MacBlane

2. Date of Death — Month: March; Day: 18; Year: 2001

3. Time of Death: 1:00 AM

4a. Facility Name *(If not institution, give street and number)*: Lorien-Riverside Nursing & Rehab. Center

4b. City, Town, or Location of Death: Belcamp

4c. County of Death: Harford

Funeral Director

5. Social Security Number: 173-09-0634

6. Sex: 1 ☒ M 2 ☐ F

7. Age *(In yrs. last birthday)*: 96 Yrs. — If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: 11/09/1904

9. Birthplace *(State or Foreign Country)*: PA

Usual Residance of Decedent

10a. State: Md.

10b. County: Harford

10c. City, Town or Location: Abingdon

10d. Inside City Limits: 1 ☐ Yes 2 ☒ No

10e. Street and Number: 304 Regal Drive

10f. Zip Code: 21009

10g. Citizen of What Country?: U.S.A.

11. Meritel Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced

12. Wes Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yas, Giva Yeer or Dates:

13. Wes Decedent of Hispanic Origin? (Specify Yes or No- II Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No *Specify:*

14. Raca - American Indian, Black, White, etc. *Specify:* white

15. Decedent's Education *(Specify only highest grade completed)*: Elementery/Secondary (0-12): 12th grade; College (1-4or 5+):

16a. Decedent's Usual Occupetion *(Give kind of work done during most of working life. DO NOT use retired)*: machinist

16b. Kind of Business/Industry: mechanical

17. Father's Name *(First, Middle, Last)*: David MacBlane

18. Mother's Name *(First, Middle, Maiden Surname)*: Agnes Hutchinson MacBlane

19a. Interment's Name/Reletionship *(Type, Print)*: Myrna Scherer

19b. Melling Address *(Street end Number or Rural Route Number, City or Town, State, Zip Code)*: 304 Regal Drive, Abingdon, Md. 21009

20a. Method ol Disposition: 1 ☒ Buriel 2 ☐ Cremetion 3 ☐ Removal trom Stete 4 ☐ Donetion 5 ☐ Other *(Specify)*

20b. Plece ol Disposition *(Nama of cemetery, cremetory or other piece)*: Christ Lutheran Church Cem. Date: 3/19/2001

20c. Location - City or Town, Stete: Baltimore, Md.

21. Signature of Funeral Service Licensee: Krishna L. David

22. Neme end Address ol Fecility: Schimunek Funeral Home of BelAir, Inc. 610 W. MacPhail Road, Bel Air, Md. 21014

Physician /Medical Examiner

23a. Part I. Enter the disease, or complicetions thet caused the deeth. Do not antar the mode ot dying, such es cardiec or respiretory arrast, shock, or heert teilure. List only ona causa on each lina.

Approximata Interval Between Onset and Death

Immediete Cause (Finel disease or condition resulting in death): a. Metastatic colon cancer

Due to (or as e consequence ot): Parkinson disease

Sequentially list conditions, if any, leeding to immedieta cause. Enter Underlying Cause (Diseese or injury that initieted events resulting in death) Last:

b. Due to (or as e consequence ot):

c. Due to (or es a consequence ot):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: hypertension, dementia, aremia, mild renal failure

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Wes an eutopsy performed? 1 ☐ Yes 2 ☐ No

24b. Were autopsy findings available prior to complation of cause of death? 1 ☐ Yes 2 ☐ No

25. Wes case referred to medical examinar? 1 ☐ Yes 2 ☒ No

26. Place ot Death *(Check only one)*: Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA; Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other *(Specify)*

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Place ol Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28b. Time ol Injury: M

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Dete ol Injury *(Month, Dey Year)*

28f. Location *(Street end Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 ☒ **Certifying Physician:** To the best of my knowledga, daeth occurred et the time, dete and place, and due to the cause(s) and manner es stated. 2 ☐ **Medical Examiner:** On the basis ot examinetion and/or investigetion, in my opinion, deeth occurred at tha tima, data and place, and dua to tha cause(s) and menner steted.

29b. Signeture and title of certifier: [signature]

29c. Licensa number: D27925

29d. Dete signed *(Month, Day, Year)*: 3/20/01

30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print): DAVID McClure MD 615 Macphail rd Bel Air, MD 21014

State Registrar

31. Dete filed *(Month, Dey, Year)*: MAR 21 2001

32. Registrer's Signeture: [signature]

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If Item 27 is marked other than 'natural', or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 10212

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Wilbur Anderson Morral

2. Data of Death (Month, Day, Year): Mar 14, 2001

3. Time of Death: 06:05pm

4a. Facility Name (If not institution, give street and number): 14620 New Georges Creek Road

4b. City, Town, or Location of Death: Frostburg

4c. County of Death: Allegany

Funeral Director

5. Social Security Number: 213-24-9789

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 72 Yrs. | If Under 1 Yaar: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Data of Birth (Month, Day, Year): May 14, 1928

9. Birthplace (State or Foraign Country): PA

Usual Rasidanca of Decedant

10a. State: MD

10b. County: Allegany

10c. City, Town or Location: Oldtown

10d. Insida City Limits: 1 [ ] Yas [X] No

10e. Street and Number: 17521 Oldtown Road, SE

10f. Zip Coda: 21555

10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Navar Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Dacedant Evar in U.S. Armed Forces? 1 [ ] Yas 2 [X] No If Yas, Giva Yaar or Datas:

13. Was Decedant of Hispanic Origin? (Specify Yas or No- If Yas, specify Cuban, Maxican, Puarto Rican, atc.): 1 [ ] Yas 2 [X] No Specify:

14. Race - American Indian, Black, White, atc. Specify: White

15. Decedant's Education (Specify only highast grada completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):

16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired): heavy eqpt operator

16b. Kind of Businass/Industry: Local 37 Engineers

17. Fathar's Nama (First, Middla, Last): Marvin Morral Sr.

18. Mothar's Nama (First, Middla, Maiden Surnama): Lona (Ketterman)

19a. Informant's Name/Ralationship (Type, Print): Regina M. Morral wife

19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda): 17521 Oldtown Road, SE;Oldtown, MD21555

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cramation 3 [ ] Ramoval from Stata 4 [ ] Donation 5 [ ] Othar (Specify)

20b. Place of Disposition (Nama of camatary, cramatory or othar placa): Sunset Memorial Park

Data: 3/17/

20c. Location - City or Town, Stata: 2001 Cumberland, MD

21. Signatura of Funaral Sarvica Licensee: Nicholas J. Scarpelli

22. Nama and Addrass of Facility: Scarpelli Funeral Home P.A. Cumberland, Maryland 21502

Physician /Medical Examiner

23a. Part1. Entar tha disaasa, or complications that caused tha daath. Do not antar tha moda of dying, such as cardiac or raspiratory arrast, shock, or haart failura. List only ona causa on aach lina.

Approximate Intarval Batween Onset and Daath

Immadiata Causa (Final disaasa or condition rasulting in death)

a. MYELODYSPLASTIC SYNDROME — ONE YEAR

Dua to (or as a consequanca of):

Sequantially list conditions, if any, laading to immadiata cause. Entar Undarlying Causa (Disaasa or injury that initiatad avants rasulting in daath) Last

b.

Dua to (or as a consequanca of):

c.

Dua to (or as a consequanca of):

d.

Part II. **Other significant conditions** contributing to death but not rasulting in tha undarlying causa givan in Part I.: PULMONARY AMYLOIDOSIS

23b. Did tobacco use contributa to the cause of death? 1 [ ] Yas 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yas 2 [X] No

24b. Wara autopsy findings available prior to compiation of cause of death? 1 [ ] Yas 2 [ ] No

25. Was casa rafarrad to medical examinar? 1 [ ] Yas 2 [X] No

26. Placa of Death (Check only ona): Hospital: 1 [ ] Inpatiant 2 [ ] ER/Outpatiant 3 [ ] DOA Othar: 4 [ ] Nursing Homa 5 [ ] Residance 6 [X] Othar (Specify) Daughter's home

27. Mannar of Death: 1 [X] Natural 2 [ ] Accidant 3 [ ] Suicida 4 [ ] Homicida 5 [ ] Pending investigation 6 [ ] Could not be datarmined

28a. Data of Injury (Month, Day Yaar):

28b. Tima of Injury:

28c. Injury at Work? 1 [ ] Yas 2 [ ] No

28d. Dascribe how injury occurrad:

28a. Placa of Injury - At homa, farm, straat, factory, offica building, atc. (Specify):

28f. Location (Street and Number or Rural Routa Number, City or Town, Stata):

29a. Cartifiar (Check only one): 1 [X] **Certifying Physician:** To tha bast of my knowledga, daath occurrad at tha tima, data and placa, and dua to tha causa(s) and mannar as stated. 2 [ ] **Medical Examiner:** On tha basis of axamination and/or invastigation, in my opinion, daath occurrad at tha tima, data and placa, and dua to tha causa(s) and mannar stated.

29b. Signatura and title of cartifiar: MD

29c. Licansa number: D33417

29d. Data signed (Month, Day, Year): MARCH 19, 2001

30. Nama and addrass of parson who complatad causa of daath (Itam 23a) (Type, Print): James R. Moen M.D. 1068 National Highway LaVale MD 21502

State Registrar

31. Data filed (Month, Day, Year): MAR 20 2001

32. Registrar's Signature: Lenora B Sparks

DHMH 16 Rav 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

6

MD

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 10213

ETHEL MILTENBERGER 214-07-4128 Baltimore, Maryland 21215-0036

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: ETHEL CHRISTINE MILTENBERGER
2. Date of Death: Month 03 Day 16 Year 2001
3. Time of Death: 21:25
4a. Facility Name *(If not institution, give street and number)*: MEMORIAL HOSPITAL
4b. City, Town, or Location of Death: CUMBERLAND
4c. County of Death: ALLEGANY

Funeral Director

5. Social Security Number: 214-07-4128
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 88 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: JAN. 19,1913
9. Birthplace *(State or Foreign Country)*: PENNSYLVANIA

Usual Residence of Decedent

10a. State: MD
10b. County: ALLEGANY
10c. City, Town or Location: CUMBERLAND
10d. Inside City Limits: 1☐ Yes 2☒ No
10a. Street and Number: 12117 BEDFORD ROAD, N.E.
10f. Zip Code: 21502
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☐ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* WHITE

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12) / College (1-4or 5+): 2
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: HOMEMAKER
16b. Kind of Business/Industry: HOME

17. Father's Name *(First, Middle, Last)*: CHARLES WATSON CLARK
18. Mother's Name *(First, Middle, Maiden Surname)*: CHRISTINE AGNES BOWEN

19a. Informant's Name/Relationship *(Type, Print)*: PHILIP MILTENBERGER / SON
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 12117 BEDFORD ROAD, N.E., CUMBERLAND, MD 21502

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: SS. PETER & PAUL CEMETERY — Date: 03/20/2001
20c. Location - City or Town, State: CUMBERLAND, MD

21. Signature of Funeral Service Licensee: Wendy A. Upchurch
22. Name and Address of Facility: UPCHURCH FUNERAL HOME, P.A. 202 GREENE ST., CUMBERLAND, MD 21502

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. CORONARY ARTERY DISEASE — 3 YEARS

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death *(Check only one)*: Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*
27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined
28a. Date of Injury *(Month, Day, Year)*
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier
29c. License number: D36766
29d. Date signed *(Month, Day, Year)*: MARCH 19, 2001
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): POONAI, VIK, M.D., 924 SETON DRIVE, CUMBERLAND, MD 21502

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

State Registrar

31. Date filed *(Month, Day, Year)*: MAR 20 2001
32. Registrar's Signature: Barbara B Sparks

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 10214

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: BRENDA H. MOORE

2. Date of Death Month / Day / Year: March 10 2001

3. Time of Death: 8:45 p.m.

4a. Facility Name *(If not institution, give street and number)*: 936 Seton Drive, Apt. # 9

4b. City, Town, or Location of Death: Cumberland

4c. County of Death: Allegany

Funeral Director

5. Social Security Number: 235-74-1692

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 51 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Oct. 14, 1949

9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: MD

10b. County: Allegany

10c. City, Town or Location: Cumberland

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 936 Seton Drive, Apt. # 9

10f. Zip Code: 21502

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12) / College (1-4or 5+): 1

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Customer Service Representative

16b. Kind of Business/Industry: Health Care Insurance

17. Father's Name *(First, Middle, Last)*: Carl R. Hamrick

18. Mother's Name *(First, Middle, Maiden Surname)*: Dora Mildred Mauk

19a. Informant's Name/Relationship *(Type, Print)*: William J. Roberts/Husband

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 936 Seton Drive, Apt. # 9 Cumberland, MD 21502

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Indian Mound Cemetery

Date: March 14 2001

20c. Location - City or Town, State: Romney, WV

21. Signature of Funeral Service Licensee: ▶ Brian L Smith

22. Name and Address of Facility: Smith Funeral Home 85 S. Main Street Keyser, WV 26726

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Finel disease or condition resulting in death)

a. Gall bladder Cancer — Unknown

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contributa to the causa of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings eveileble prior to completion of causa of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☒ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, ferm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and piece, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ MAEM MD

29c. License number: D54756

29d. Date signed *(Month, Day, Year)*: March 21, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Robert E. Rapp, M.D. 912 Seton Drive Cumberland, MD 21502

State Registrar

31. Date filed *(Month, Day, Year)*: MAR 21 2001

32. Registrar's Signature: ▶ Barbara B Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

8/6

MS

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 10215

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month / Day / Year	3. Time of Death
COELINE GENEVIA MONTANA	March 21, 2001	21:35 pM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
SACRED HEART HOSPITAL	CUMBERLAND	ALLEGANY

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
220 10 7297	1☐M 2☒F	81 Yrs.			AUG 1 1919	MARYLAND

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MARYLAND	ALLEGANY	FROSTBURG	1☒Yes 2☐No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
93 MT. PLEASANT STREET	21532	U.S.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐Never Married 2☐Married 3☒Widowed 4☐Divorced	1☐Yes 2☒No If Yes, Give Year or Dates:	1☐Yes 2☒No Specify:	Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
8		CONING DEPARTMENT	CELANESE CORP.

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
WAYNE LASHLEY	ISABELLA LYNCH

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
MARY THERES KISAMORE / DAUGHTER	13200 DEY RIDGE RD, FLINTSTONE, MD 21530

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place) / Date	20c. Location - City or Town, State
1☐Burial 2☒Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	THE CUMBERLAND CREMATORY 3/22/01	CUMBERLAND, MD

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
Eric Sowers	SOWERS FUNERAL HOME, P.A. 60 W. MAIN ST., FROSTBURG, MD 21532

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)	a. CEREBROVASCULAR ACCIDENT	7 DAYS
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of): b.	
	Due to (or as a consequence of): c.	
	Due to (or as a consequence of): d.	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month / Day / Year
1☐Yes 2☑No 9☐Unknown	1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) _____ 9☐Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☑No 3☐Probably 4☐Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐Yes 2☑No	1☐Yes 2☑No

Medical Certification; To Be Completed by Physician/Medical Examiner

25. Was case referred to medical examiner?	28. Place of Death (Check only one)	
1☐Yes 2☑No	Hospital: 1☑Inpatient 2☐ER/Outpatient 3☐DOA	Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☑Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined		M	1☐Yes 2☐No	
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1☑**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ MD	D5093	March 22, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): VIRGINIA C. MACBOJOS 912 SETON DRIVE CUMBERLAND, MD 21502

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
MAR 23 2001	Sandra G Sparks

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

YES

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 10216

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): GILBERT EDWARD MYERS
2. Date of Death: Month March, Day 22, Year 2001
3. Time of Death: 9:00A M
4a. Facility Name (If not institution, give street and number): SACRED HEART HOSPITAL
4b. City, Town, or Location of Death: CUMBERLAND
4c. County of Death: ALLEGANY

Funeral Director

5. Social Security Number: 198 18 7085
6. Sex: 1☒ M 2☐ F
7. Age (In yrs. last birthday): 74 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): MAY 1 1926
9. Birthplace (State or Foreign Country): PENNSYLVANIA

Usual Residence of Decedent

10a. State: PA
10b. County: SOMERSET
10c. City, Town or Location: ADDISON
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 631 MAIN STREET
10f. Zip Code: 15411
10g. Citizen of What Country?: U.S.

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Wes Decedent Ever in U.S. Armed Forces? 1☒ Yes 2☐ No If Yes, Give Year or Dates: WW II
13. Wes Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Rece - Americen Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 8; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): TRUCK DRIVER
16b. Kind of Business/Industry: SNAVELY FOREST PRODUCTS

17. Father's Name (First, Middle, Last): WILLIAM NEWTON MYERS
18. Mother's Neme (First, Middle, Meiden Surname): MARY FISHER

19a. Informant's Name/Relationship (Type, Print): GRACE E. MYERS / WIFE
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 631 MAIN STREET, ADDISON, PA 15411

20a. Method of Disposition: 1☒ Burial 2☐ Cremetion 3☐ Removel from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other piece): ADDISON CEMETERY
Dete: 3/25/01
20c. Location - City or Town, State: ADDISON, PA 15411

21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: SOWERS FUNERAL HOME, P.A. 60 W. MAIN ST., FROSTBURG, MD 21532

Physician /Medical Examiner

23a. Part1. Enter the disease, or complicetions that caused the death. Do not enter the mode ot dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one ceuse on each line.

Approximete Intervet Between Onset and Death

Immediate Cause (Finet disease or condition resulting in death)
a. CONGESTIVE HEART FAILURE — FIVE YEARS

Due to (or as a consequence of):
b. CARDIOMYOPATHY — SIX YEARS

Sequentially list conditions, if any, leading to immediete cause. Enter Underlying Cause (Disease or injury thet initiated events resulting in death) Last

Due to (or as e consequence of):
c. Myocardial Infarctions — about 6yrs

Due to (or as e consequence of):
d. Coronary artery disease — about 6-7yrs

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐ Yes 2☐ No 9☐ Unknown
23c. If yes, outcome of pregnancy 1☐ Live birth 2☐ Fetal deeth 3☐ Ectopic pregnency 4☐ Pregnant et time ot deeth 5☐ Other (specify) _____ 9☐ Unknown
23d. Dete ot delivery Month Dey Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Part I.
Chronic Obstructive Lung Disease
Diabetes mellitus. Major depression

23e. Did tobecco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probebly 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were eutopsy findings available prior to completion of ceuse of deeth? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

28. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 8☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rurel Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physicien**: To the best of my knowledge, death occurred et the time, date and place, and due to the cause(s) end manner es steted. 2☐ **Medical Exeminer:** On the basis of exeminetion and/or investigation, in my opinion, deeth occurred at the time, date and piece, end due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature]
29c. License number: D26907
29d. Date signed (Month, Dey, Yeer): March 23, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Harjit S. Sidhu, M.D., 925 Bishop Walsh Rd., Cumberland, MD 21502

State Registrar

31. Date filed (Month, Dey, Year): MAR 23 2001
32. Registrar's Signature: [signature]

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or if items 28e or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification; To Be Completed by Physician/Medical Examiner

Amended #20b, mlo, 3/26/01, Allegany Co.

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 10217

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
JAMES ANTHONY MICHAELS	March 20 2001	6:42 PM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
14604 Barrellville Road	Mt. Savage	Allegany

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
214 34 2030	1☒ M 2☐ F	64 Yrs.			7-8-1936	MD

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	Allegany	Mt. Savage	1☐ Yes 2☒ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
14604 Barrellville Road	21545	USA

11. Marital Status	12. Was Decedent Evar in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐ Nevar Married 2☒ Married 3☐ Widowed 4☐ Divorced	1☐ Yas 2☒ No If Yes, Giva Year or Dates:	1☐ Yes 2☒ No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12		Laborer	Manufacturing

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Wilbert Paul Michaels, Sr.	Edna Claire Keller

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code)
Viola H. Michaels	14604 Barrellville Road, Mt. Savage, MD 21545

20a. Method of Disposition	20b. Placa of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒ Burial 2☐ Cramation 3☒ Removal from Stata 4☐ Donation 5☐ Other (Specify)	Hyndman Cemetery	3-23-2001 ~~3-25-2001~~	Hyndman, PA

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ Harvey H Zeigler	Harvey H. Zeigler Funeral Home 169 Clarence Street, Hyndman, PA 15545

Physician /Medical Examiner

23a. Part1. Entar the disaase, or complications that causad tha daath. Do not antar tha moda of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediata Cause (Final disaase or condition resulting in death)	a. Hypertensive cardiovascular heart disease	uk yrs
	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immadiate cause. Enter Underlying Cause (Disease or Injury thet initiated events resulting in death) Last	b.	
	Due to (or as a consequence of):	
	c.	
	Due to (or as a consequence of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐ Yes 2☒ No	1☐ Yas 2☐ No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☒ Yes 2☐ No	Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA	Other: 4☐ Nursing Home 5☒ Residenca 8☐ Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒ Natural 2☐ Accident 3☐ Suicida 4☐ Homicida 5☐ Pending investigetion 6☐ Could not be determined		M	1☐ Yes 2☐ No	

28e. Piece of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1☐ **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, dete end place, and due to the cause(s) and manner es stated. 2☒ **Medical Examiner:** On tha basis of examinetion and/or invastigation, in my opinion, death occurred at the time, date and placa, end due to the cause(s) and manner steted.

29b. Signature and title of certifier	29c. Licansa number	29d. Date signed (Month, Day, Year)
▶ Dpty Med Ex	D 09157	March 21 2001

30. Name and address of person who completed causa of death (Item 23a) (Type, Print)

Paul Snow 124 W 3rd St Cumberland MD 21502

State Registrar

31. Data filed (Month, Day, Year)	32. Registrar's Signatura
MAR 21 2001	

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

10

MLS

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 10218

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): ELIZABETH GRACE MILLER

2. Date of Death: Month 03 Day 24 Year 2001

3. Time of Death: 19:12

4a. Facility Name (If not institution, give street and number): MEMORIAL HOSPITAL

4b. City, Town, or Location of Death: CUMBERLAND

4c. County of Death: ALLEGANY

Funeral Director

5. Social Security Number: 220-10-7595

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 82 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): OCT 12 1918

9. Birthplace (State or Foreign Country): MARYLAND

Usual Residence of Decedent

10a. State: MARYLAND

10b. County: ALLEGANY

10c. City, Town or Location: CUMBERLAND

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 14002 BEDFORD STREET

10f. Zip Code: 21502

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 8

College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): CO OWNER MT VIEW MOTEL & APTS

16b. Kind of Business/Industry: MOTEL & APTS OWNER

17. Father's Name (First, Middle, Last): CRAIGEON E. HAMILTON

18. Mother's Name (First, Middle, Maiden Surname): JULIA MAY BOGGS

19a. Informant's Name/Relationship (Type, Print): CEDRIC LEE MILLER SON

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 323 SKYVIEW DRIVE LAVALE, MARYLAND 21502

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): HILLCREST CEMETERY

Date: MARCH 28 2001

20c. Location - City or Town, State: CUMBERLAND MARYLAND

21. Signature of Funeral Service Licensee: Dale L. Merritt

22. Name and Address of Facility: MERRITT-ADAMS FUNERALHOME P.A. 404 DECATUR STREET CUMBERLAND MARYLAND

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Cerebral hemorrhage — 3 days

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Cerebral atherosclerosis — 15 years

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Chronic renal failure, secondary to diabetic nephropathy, cardiomyopathy ventricular irritability, thrombolytic therapy for occluded arteriovenous fistula

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Ranjithan

29c. License number: D19318

29d. Date signed (Month, Day, Year): MARCH 25TH, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): RANJITHAN, N.A., M.D., 517 OLDTOWN ROAD, CUMBERLAND, MD 21502

State Registrar

31. Date filed (Month, Day, Year): MAR 26 2001

32. Registrar's Signature: Bonnie D Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

220-10-7595 GRACE MILLER

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

6

YKS

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 10219

NAME KNOWN TO PHYSICIAN: NICHOLSON, GERALD B.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
Gerald Bradford Nicholson	MARCH 17, 2001	2:20PM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
VA MARYLAND HEALTH CARE SYSTEM	PERRY POINT	CECIL

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
236-20-5718	1☒ M 2☐ F	78 Yrs.			Sept. 17, 1922	West Virginia

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Harford	Bel Air	1☒ Yes 2☐ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
136 East Pennsylvania Avenue	21014	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced	1☒ Yes 2☐ No If Yes, Give Year or Dates:	1☐ Yes 2☒ No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12		Military	U.S. Government

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Charles Winford Nicholson	Effie u/k Kelly

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Alpha H. Nicholson- Wife	136 East Pennsylvania Avenue, Bel Air, Maryland 21014

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)	Bel Air Memorial Gardens	3/21/2001	Bel Air, Maryland

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ Stephen A Murphy	McComas Funeral Home, P.A. 50 W. Broadway Street, Bel Air, Maryland 21014

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. PROSTATE CANCER WITH METASTASIS	UNKNOWN
	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	b.	
	Due to (or as a consequence of):	
	c.	
	Due to (or as a consequence of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐ Yes 2☒ No	1☐ Yes 2☐ No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐ Yes 2☒ No	Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA	Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined		M	1☐ Yes 2☐ No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and mannar as stated.
2☐ **Medical Examiner:** On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, dete and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶	D52739	MARCH 17, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
SURESH SHANDELYA, M.D., VA MARYLAND HEALTHCARE SYSTEM, PERRY POINT, MARYLAND 21902

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
MAR 19 2001	

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 10220

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): James Gibbons Naughton Jr.

2. Date of Death: Month March Day 17 Year 2001

3. Time of Death: 1:00 PM

4a. Facility Name (If not institution, give street and number): 84 Main St.

4b. City, Town, or Location of Death: Westernport

4c. County of Death: Allegany

Funeral Director

5. Social Security Number: 214-28-7001

6. Sex: 1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday): 69 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Nov. 14, 1931

9. Birthplace (State or Foreign Country): West Virginia

Usual Residence of Decedent

10a. State: MD.

10b. County: Allegany

10c. City, Town or Location: Westernport

10d. Inside City Limits: ☒ Yes 2 ☐ No

10e. Street and Number: 84 Main St.

10f. Zip Code: 21562

10g. Citizen of What Country? United States

11. Meritel Stetus: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 ☒ Yes 2 ☐ No If Yes, Give Year or Dates: Korean War

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indien, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondery (0-12): 12

College (1-4or 5+): 2

16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired): laborer

16b. Kind of Business/Industry: Westvaco Paper Manufacturer

17. Father's Name (First, Middle, Last): James Gibbons Naughton Sr.

18. Mother's Neme (First, Middle, Maiden Surname): Nina E. Legge

19a. Informent's Neme/Relationship (Type, Print): Rose Naughton/ wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code): 84 Main St., Westernport, Maryland 21562

20a. Method of Disposition: 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

20b. Piece of Disposition (Name of cemetery, crematory or other place): Cumberland Crematory

Dete: 03/18/2001

20c. Location - City or Town, Stete: Cumberland, Maryland

21. Signature of Funerel Service Licensee: ▶ F. Wayne Boal

22. Neme and Address of Facility: Boal Funeral Home 111 Church St., Westernport, Maryland 21562

Physician /Medical Examiner

23a. Part1. Enter the diseese, or complicetions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line.

Approximete Interval Between Onset and Deth

Immediate Cause (Finel disease or condition resulting in death)

a. pancreatic carcinoma — 1 year

Due to (or es e consequence of):

Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Diseese or Injury that initieted events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or es e consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Wes an autopsy performed? 1 ☐ Yes 2 ☒ No

24b. Were autopsy findings eveilable prior to completion of cause of death? 1 ☐ Yes 2 ☒ No

25. Was casa referred to medical examiner? 1 ☐ Yes 2 ☒ No

26. Place of Deeth (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Menner of Death: 1 ☒ Netural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Dete of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Piece of Injury - At home, ferm, street, factory, office building, etc. (Specify)

28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1 ☒ **Certifying Physicfan**: To the best of my knowledge, deeth occurred at the time, date end piece, end due to the cause(s) end manner as stated. 2 ☐ **Medicat Examiner**: On the basis of examination and/or investigetion, in my opinion, deeth occurred at the time, date and piece, and due to the cause(s) and manner steted.

29b. Signeture and title of certifier: ▶ Roy Christoln, MD

29c. License number: D34302

29d. Date signed (Month, Day, Year): 3/18/01

30. Nama and address of person who completed cause of death (Item 23a) (Type, Print): Roy Christolm, M.D. 924 Seton Dr. Cumberlnd, MD 21502

State Registrar

31. Dete filed (Month, Day, Year): MAR 19 2001

32. Registrar's Signature: ▶ Geneva G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires thet the deeth certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 10221

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Donald Emmett O'Connor

2. Date of Death Month Day Year: March 21, 2001

3. Time of Death: 11:40 am

4e. Facility Name *(If not institution, give street and number)*: Charles County Nursing & Rehab. Center

4b. City, Town, or Location of Death: La Plata

4c. County of Death: Charles

Funeral Director

5. Social Security Number: 171-07-3360

6. Sex: 1 [X] M 2 [ ] F

7. Age *(In yrs. last birthday)*: 84 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: NOVEMBER 13,1916

9. Birthplace *(State or Foreign Country)*: OHIO

Usual Residence of Decedent

10e. State: MARYLAND

10b. County: PRINCE GEORGE'S

10c. City, Town or Location: BRANDYWINE

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street end Number: 10505 CEDARVILLE ROAD, 7-4

10f. Zip Code: 20613

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No — If Yes, Give Year or Dates: USA 1945-1946

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 [ ] Yes 2 [X] No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 / College (1-4or 5+): 0

16e. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: PLUMBING & HEATING ESTIMATOR

16b. Kind of Business/Industry: PLUMBING & HEATING

17. Father's Name *(First, Middle, Last)*: JOSEPH C. O'CONNOR

18. Mother's Name *(First, Middle, Maiden Surname)*: ELIZABETH BRANT

19e. Informant's Name/Relationship *(Type, Print)*: MIKE O'CONNOR / SON

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: P.O. BOX 396, COBB ISLAND, MARYLAND 20625

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: MARYLAND VETERANS CEMETERY

Date: 3/28/2001

20c. Location - City or Town, State: CHELTENHAM, MARYLAND

21. Signature of Funeral Service Licensee: JOHN P. KNISLEY M01164

22. Name and Address of Facility: THE HUNTT FUNERAL HOME, INC. P.O.BOX 156, WALDORF, MARYLAND 20604

JPK

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

e. Congestive Heart Failure

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Coronary Artery Disease

Due to (or as a consequence of):

c. Diabetes mellitus

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death *(Check only one)*: Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — Other: 4 [X] Nursing Home 5 [ ] Residence 6 [ ] Other *(Specify)*

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29e. Certifier *(Check only one)*: 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Michael C Leatherwood

29c. License number: D0021031

29d. Date signed *(Month, Day, Year)*: MARCH 22, 2001

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): MICHAEL A. LEATHERWOOD, MD, 12070 OLD LINE CENTER, #202, WALDORF, MD 20602

State Registrar

31. Date filed *(Month, Day, Year)*: MAR 23 2001

32. Registrar's Signature: Jane G. Sparks

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar Amend Item #4c per PHYG795 5/4/2001 EK

Certificate of Death

Reg. No. 2001 10222

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)			2. Date of Death Month	Day	Year	3. Time of Death
HELEN		OTTO	MARCH	18	2001	7:10 PM

4e. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
JOHNS HOPKINS BAYVIEW MEDICAL CENTER	BALTIMORE	~~BALTIMORE~~ Balto. City

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months	Days	If Under 24 Hrs.: Hours	Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
213-24-8159	1☐M 2☒F	91 Yrs.					May 16 1909	MD

Usual Residence of Decedent

10e. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	Baltimore	Essex	1☐Yes 2☒No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
340 Sassafras Road	21221	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐Never Married 2☐Married 3☒Widowed 4☐Divorced	1☐Yes 2☒No If Yes, Give Year or Dates:	1☐Yes 2☒No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	18b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
6		Seamstress	L. Greif Clothing

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Hezekiah Steele	Minnie Lambert

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Charles Otto, Jr./son	340 Sassafras Rd Essex, MD 21221

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	Mt. Zion Cemetery	3/21/2001	Finksburg, MD

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶	Pritts Funeral Home and Chapel 412 Washington Rd Westminster, MD 21157

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. ASPIRATION PNEUMONIA	ONE DAY
Due to (or as a consequence of):	b. GASTRO INTESTINAL BLEEDING	TWO DAYS
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c.	
Due to (or as a consequence of):	d.	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month Day Year
1☐Yes 2☒No 9☐Unknown	1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐Yes 2☒No	1☐Yes 2☐No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐Yes 2☒No	Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA	Other: 4☐Nursing Home 5☐Residence 8☐Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined		M	1☐Yes 2☐No	
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ MD	RES-000	MARCH 18 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

EVELYN MENTARI, MD 4940 EASTERN AVENUE BALTIMORE MARYLAND 21224

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
MAR 19 2001	▶ Geneva B Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 28a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

CEW 2

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 10223

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month / Day / Year	3. Time of Death
JOHN HUGH O'ROURKE	March 18 2001	1150 A M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
SACRED HEART HOSPITAL	CUMBERLAND	ALLEGANY

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
218 30 2451	1 [X] M 2 [ ] F	71 Yrs.			OCT 30 1929	MARYLAND

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MARYLAND	ALLEGANY	FROSTBURG	1 [ ] Yes 2 [X] No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
87 ARMSTRONG STREET	21532	U.S.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced	1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:	1 [ ] Yes 2 [X] No Specify:	Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
	3	COUNSELOR	JUVENILE SERVICES

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
JOHN O'ROURKE	ELEANOR FESTERMAN

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
KENNETH O'ROURKE / BROTHER	16718 LOARTOWN ROAD, SW, FROSTBURG, MD 21532

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	FROSTBURG MEMORIAL PARK	3/21/01	FROSTBURG, MD

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
[signature]	SOWERS FUNERAL HOME, P.A. 60 W. MAIN ST., FROSTBURG, MD 21532

Physician /Medical Examiner

Medical Certification; To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. MI	3 days
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. CVA	3 days
	c.	
	d.	

Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1 [ ] Yes 2 [ ] No 9 [ ] Unknown

23c. If yes, outcome of pregnancy 1 [ ] Live birth 2 [ ] Fetal death 3 [ ] Ectopic pregnancy 4 [ ] Pregnant at time of death 5 [ ] Other (specify) _____ 9 [ ] Unknown

23d. Date of delivery Month / Day / Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

DM

23e. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1 [ ] Yes 2 [X] No	1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1 [ ] Yes 2 [X] No	Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA	Other: 4 [ ] Nursing Home 5 [ ] Residence 8 [ ] Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined		M	1 [ ] Yes 2 [ ] No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1 [X] **Certifying Physician:** To the best of *my* knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
[signature] Pulmonary/ Critical care	H0053855	March 20, 2001

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Stanley Joseph Matyasik D.O. Sacred Heart Hospital, Cumberland MD. 21502

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
MAR 21 2001	[signature]

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or item 23e or 28e-1 show any injury or other traumatic event, the Medical Examiner must be notified as soon as possible.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

10

MD

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 10224

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
RAYMOND MILLARD ORNDORFF, SR.	3-21-2001	6:16 A M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
WMHS Sacred Heart Hospital	Cumberland	Allegany

Funeral Director

5. Social Security Number	8. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
217 10 7283	1 [X] M 2 [ ] F	87 Yrs.			6-16-1913	MD

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	Allegany	Ellerslie	1 [X] Yes 2 [ ] No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
13914 Old Schellsburg Road	21529	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced	1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: WWII	1 [ ] Yes 2 [X] No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	18b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
6		Sales	Wholesale Trade

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Unknown	Mary (mnu) Orndorff

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Donald Orndorff, son	P. O. Box 460, Ellerslie, MD 21529

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	Sunset Memorial Park	3-24-2001	Cumberland, MD

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ Harvey H Zeigler	Harvey H. Zeigler Funeral Home, Hyndman, PA

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. ACUTE RESPIRATORY FAILURE	3
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of): CONGESTIVE HEART FAILURE	5 years
	c. Due to (or as a consequence of): CORONARY ARTERY DISEASE	10 years
	d. Due to (or as a consequence of):	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month Day Year
1 [ ] Yes 2 [ ] No 9 [ ] Unknown	1 [ ] Live birth 2 [ ] Fetal death 3 [ ] Ectopic pregnancy 4 [ ] Pregnant at time of death 5 [ ] Other (specify) 9 [ ] Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1 [ ] Yes 2 [X] No	1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner?	28. Place of Death (Check only one)	
1 [ ] Yes 2 [X] No	Hospital: 1 [ ] Inpatient 2 [X] ER/Outpatient 3 [ ] DOA	Other: 4 [ ] Nursing Home 5 [ ] Residence 8 [ ] Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 8 [ ] Could not be determined		M	1 [ ] Yes 2 [ ] No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification; To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one) 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ [signature] PHYSICIAN	D50844	03/22/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
JOSE F. LOUREIRO JR., MD 912 SETON DRIVE CUMBERLAND, MD 21502

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
MAR 23 2001	▶ [signature]

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

10

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 10225

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Jonathan Philip Pascoe
2. Date of Death (Month, Day, Year): March 16 2001
3. Time of Death: 9:30 am.

4a. Facility Name (If not institution, give street and number): 4500 Millers Station Rd.
4b. City, Town, or Location of Death: Hampstead
4c. County of Death: Carroll

Funeral Director

5. Social Security Number: 213-23-0242
6. Sex: 1☐ M 2☐ F
7. Age (In yrs. last birthday): 12 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Sept. 9, 1988
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Carroll
10c. City, Town or Location: Hampstead
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 4500 Millers Station Rd.
10f. Zip Code: 21074
10g. Citizen of What Country: U.S.A.

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12) / College (1-4or 5+)
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): never worked
16b. Kind of Business/Industry: never worked

17. Father's Name (First, Middle, Last): Philip N. Pascoe
18. Mother's Name (First, Middle, Maiden Surname): Judith A. Pascoe

19a. Informent's Name/Reletionship (Type, Print): Philip N. Pascoe - father
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4500 Millers Station Rd. Hampstead, Md. 21074

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, cremetory or other place): Millers Church Cem. | Date: March 19, 2001
20c. Location - City or Town, State: Millers, Md.

21. Signature of Funeral Service Licensee: Justin R. Dunbar
22. Name and Address of Facility: Eckhardt Funeral Chapel P.A. 3296 Charmil Dr. Manchester, Md. 21102

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Hypoxic-ischemic encephalopathy	12 yrs
	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Reactive airway disease	
	Due to (or as a consequence of):	
	c. Seizure disorder	
	Due to (or as a consequence of):	
	d. Gastroesophageal reflux	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Part I.

Osteoporosis

Oxygen requirment at home

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of ceuse of death? 1☐ Yes 2☒ No

25. Wes case referred to medicel examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year): N/A
28b. Time of Injury: M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred: N/A
28e. Piece of Injury - At home, ferm, street, factory, office building, etc. (Specify): N/A
28f. Location (Street and Number or Rurel Route Number, City or Town, State): N/A

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner es stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigetion, in my opinion, deeth occurred at the time, date and place, end due to the cause(s) and manner stated.

29b. Signature and title of certifier: Michael A. Ruiz M.D.
29c. License number: D0055560
29d. Date signed (Month, Day, Year): 3/16/01

30. Name and address of person who completed ceuse of death (Item 23a) (Type, Print): Michael A. Ruiz, Clinical Associates PA, 750 Main Street, Reisterstown, MD 21136

State Registrar

31. Date filed (Month, Day, Year): MAR 19 2001
32. Registrar's Signeture: Geneva B Sparks

DHMH 16 Rev 6/95

ORIGINAL

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

CEW 4

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

Amend Item 29c per BOP
03/20/2001, Carroll County, wjl

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 10226

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Charles H. Pearson
2. Date of Death: Month March Day 17 Year 2001
3. Time of Death: 2:40 Pm
4a. Facility Name (If not institution, give street and number): Franklin Square Hospital Center
4b. City, Town, or Location of Death: Rosedale
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 213 26 0866
6. Sex: 1☒ M 2☐ F
7. Age (In yrs. last birthday): 85 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Sept. 8, 1915
9. Birthplace (State or Foreign Country): Md.

Usual Residence of Decedent

10a. State: Md.
10b. County: Baltimore
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 5822 Shady Spring Ave.
10f. Zip Code: 21237
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puarto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Bookkeeper
16b. Kind of Business/Industry: Modern Trash Removal Co.

17. Father's Name (First, Middle, Last): Charles H. Pearson
18. Mother's Name (First, Middle, Maiden Surname): Carolyn Freyer

19a. Informant's Name/Ralationship (Type, Print): Julie Rainey (Daughter)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2534 Arthur Ave. Sykesville, Md. 21784

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, cremetory or other place): Lake View Memorial
Date: 3-21-01
20c. Location - City or Town, State: Sykesville, Md

21. Signature of Funeral Service Licensee: ▶ Harry W. Haight
22. Name and Address of Facility: Haight Funeral Home & Chapel P.O.Box 195 Sykesville, Md. 21784

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) a.	Myocardial infarction	3 Days
Due to (or as a consequence of): b.	Gastrointestinal Bleeding	3 Days
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting in death) Last: Due to (or as a consequence of): c.		
Due to (or as a consequence of): d.		

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No
26. Place of Death (Check only one): Hospital: 1☑ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ James L. Stuke M.D.
29c. License number: P12694 ~~D 19 27 24~~
29d. Date signed (Month, Day, Year): 3/17/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): FRANKLIN SQUARE HOSPITAL CENTER
Dr Laura, steele, 9000 franklin square Drive Baltimore md, 21237

State Registrar

31. Date filed (Month, Day, Year): MAR 2 0 2001
32. Registrar's Signature: ▶ Geneva B Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or Items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Pearson, Charles H
Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

WJL 3

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 10227

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Betty Davis Primoff
2. Date of Death (Month, Day, Year): March 16, 2001
3. Time of Death: 9:27PM
4a. Facility Name *(If not institution, give street and number)*: Pleasant View Nursing Home
4b. City, Town, or Location of Death: Mt. Airy
4c. County of Death: Carroll

Funeral Director

5. Social Security Number: 132-12-2621
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 80 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: Aug. 1, 1920
9. Birthplace *(State or Foreign Country)*: New York

Usual Residence of Decedent

10a. State: MD
10b. County: Carroll
10c. City, Town or Location: Woodbine
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 7201 Old Washington Road
10f. Zip Code: 21797
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 10 — College (1-4or 5+): 0
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Homemaker
16b. Kind of Business/Industry: Own Home

17. Father's Name *(First, Middle, Last)*: unknown
18. Mother's Name *(First, Middle, Maiden Surname)*: unknown

19a. Informant's Name/Relationship *(Type, Print)*: Edward Primoff/Son
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 7201 Old Washington Road Woodbine, MD 21797

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: George Washington Cemetery
Date: 3/19/2001
20c. Location - City or Town, State: Adelphi, MD

21. Signature of Funeral Service Licensee: Jeffrey W. Zumbrun
22. Name and Address of Facility: J.N. Zumbrun Funeral Home & Mon. Co. 6028 Sykesville Road Eldersburg, MD 21784

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. SEPSIS due to large decubitae — weeks
Due to (or as a consequence of):
b. Severe Dementia — years.
Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
c.
Due to (or as a consequence of):
d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☒ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury *(Month, Day, Year)*
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: Melvin Joel Kordon
29c. License number: D06588
29d. Date signed *(Month, Day, Year)*: 3/19/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Dr. Melvin Kordon 4801 Dorsey Hall Drive Ellicott City, MD 21042

State Registrar

31. Date filed *(Month, Day, Year)*: MAR 2 0 2001
32. Registrar's Signature: Deanna G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important:** If item 27 is marked other than "natural", or items 28a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

CEW 4

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 10228

Mary Powell SS# 217-05-3506

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

Funeral Director

To Be Completed by Funeral Director

1. Decedent's Name (First, Middle, Last): MARY WIMBROW POWELL

2. Date of Death (Month, Day, Year): March 16, 2001

3. Time of Death: 1639

4a. Facility Name (If not institution, give street and number): PENINSULA REGIONAL MEDICAL CENTER

4b. City, Town, or Location of Death: SALISBURY

4c. County of Death: WICOMICO

5. Social Security Number: 217-05-3506

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 88 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): AUG. 12, 1912

9. Birthplace (State or Foreign Country): MARYLAND

Usual Residence of Decedent

10a. State: MARYLAND

10b. County: WICOMICO

10c. City, Town or Location: SALISBURY

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 1504 MT HERMON RD

10f. Zip Code: 21804

10g. Citizen of What Country? U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 10

College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): BEAUTICIAN

16b. Kind of Business/Industry: OWN BUSINESS

17. Father's Name (First, Middle, Last): CHARLES WIMBROW

18. Mother's Name (First, Middle, Maiden Surname): LILLIE M. RICHARDSON

19a. Informant's Name/Relationship (Type, Print): REBECCA P. LANDON - DAUGHTER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 306 KAYWOOD DR SALISBURY, MD 21804

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): WANGO CEMETERY

Date: 3/20/01

20c. Location - City or Town, State: PARSONSBURG, MARYLAND

21. Signature of Funeral Service Licensee: Robert W. Harris

22. Name and Address of Facility: 705 E. MAIN ST. BOUNDS FUNERAL HOME, INC. SALISBURY, MD 21804

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. MYASTHENIA GRAVIS — 1 week

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death (Check only one)

Hospital: 1☑ Inpatient 2☐ ER/Outpatient 3☐ DOA

Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier:

29c. License number: D38353

29d. Date signed (Month, Day, Year): 3-18-01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Rene DesMARAIS 560 Riverside Dr. Salisbury, Md. 21801

State Registrar

31. Date filed (Month, Day, Year): MAR 19 2001

32. Registrar's Signature: Geneva G Sparks

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

10 DQ

DHMH 16 Rev 6/95

ORIGINAL

01-1485-045
B.K.S
ROBBIN PARSONS

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

1- For State Registrar

Reg. No. 2001 10229

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
Robbin K. Parsons	MARCH 15, 2001	1735 P M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
PENINSULA REGIONAL MEDICAL CENTER	SALISBURY	WICOMICO

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
212-80-5453	1☐M 2☒F	48 Yrs.			Feb. 23, 1953	Maryland

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	Wicomico	Salisbury	1☐Yes 2☒No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
Holly Center 926 Snow Hill Road	21801	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexicen, Puerto Ricen, etc.)	14. Race - American Indian, Black, White, atc.
1☒Never Married 2☐Married 3☐Widowed 4☐Divorced	1☐Yes 2☒No If Yes, Give Year or Dates:	1☐Yes 2☒No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
0		Never Worked	None

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Thomas C. Parsons, Sr.	Donna Vee Conyers

19a. Informent's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Donna Miles Mother	10501 Harry Byrd Hwy. Berryville, VA 22611-5237

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☐Burial 2☒Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	Crematory of Delmarva	3-19-2001	Delmar, Delaware

21. Signature of Funeral Service Licensee ▶ [signature]

22. Name and Address of Facility
Short Funeral Home
13 E. Grove Street Delmar, DE 19940

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the moda of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Finel disease or condition resulting in death)
a. Cardiac Arrhythmia

Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
b. Cardiac Hypertrophy in Association
~~Due to (or as a consequence of):~~
c. With Congenital Rubella
~~Due to (or as a consequence of):~~
d. Syndrome

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcoma of pregnancy	23d. Data of delivery Month Day Year
1☐Yes 2☒No 9☐Unknown	1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnent at time of deeth 5☐Other (specify) _____ 9☐Unknown	

Part II. Othar significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☒Yes 2☐No	1☒Yes 2☐No

25. Was cese referred to medical exeminer?	26. Place of Deeth (Check only one)	
1☒Yes 2☐No	Hospital: 1☐Inpatient 2☒ER/Outpatient 3☐DOA	Other: 4☐Nursing Home 5☐Residence 8☐Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigetion 6☐Could not be determined		M	1☐Yes 2☐No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1☐ **Certifying Physician:** To the best of my knowledge, death occurred et the time, date and place, and due to the cause(s) and manner es stated.
2☒ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred et the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ J. Pestaner	O.C.M.E	MARCH 17, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
J. Pestaner, ME 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
MAR 19 2001	▶ Denise B Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or item 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified as soon as.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires thet the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use es the burial-transit

Medical Certification; To Be Completed by Physician/Medical Examiner

IDQ

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 10230

213-24-6292

Joseph Raith

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)			2. Date of Death Month Day Year	3. Time of Death
JOSEPH	BERNARD	RAITH	March 18, 2001	0600

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
PENINSULA REGIONAL MEDICAL CENTER	SALISBURY	WICOMICO

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
213-24-6292	1 [X] M 2 [ ] F	69 Yrs.			March 20, 1931	Maryland

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Wicomico	Salisbury	1 [X] Yes 2 [ ] No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
106 S. Saratoga St.	21804	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1 [ ] Never Married 2 [ ] Married 3 [ ] Widowed 4 [X] Divorced	1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: Army	1 [ ] Yes 2 [X] No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12	1	Accountant	Petroleum Pump Mfg.

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Louis Raith	Ruth Mulligan

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Patricia Raith/Ex-Wife	1013 Pierce AVe., Salisbury, MD 21804

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	Salisbury Crematory	3/20/01	Salisbury, MD

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ J. Brn. Holloway	Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. CONGESTIVE HEART FAILURE	YRS
	Due to (or as a consequence of):	
	b. ASCVD.	YRS
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of):	
	c.	
	Due to (or as a consequence of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

COPD

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1 [ ] Yes 2 [X] No	1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1 [ ] Yes 2 [X] No	Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA	Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined		M	1 [ ] Yes 2 [ ] No	
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ D/ Hrubnick	020912	3/19/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
DENNIS CHODNICKI, M.D. 400 E. Shore Dr. SALISBURY, MD 21804

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
MAR 21 2001	▶ Penne G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

8/1 VA DQ

Please Type or Print In Black Indellble Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 10231

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Elizabeth Risko Rison

2. Date of Death Month / Day / Year: March 20 2001

3. Time of Death: 4:50PM

4a. Facility Name *(If not institution, give street and number)*: LaPlata Center Genesis Eldercare

4b. City, Town, or Location of Death: LaPlata

4c. County of Death: Charles

Funeral Director

5. Social Security Number: 220-32-5230

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 83 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

6. Date of Birth *(Month, Day, Year)*: Jan.6,1918

9. Birthplace *(State or Foreign Country)*: Pennsylvania

Usual Residence of Decedent

10a. State: MD

10b. County: Charles

10c. City, Town or Location: Ironsides

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 6240 Port Tobacco Road

10f. Zip Code: 20643

10g. Citizen of What Country?: U. S. A.

11. Meritel Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Wes Decedent Ever in U,S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yeer or Detes:

13. Wes Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - Americen Indien, Bleck, White, etc. *Specify:* White

15. Decedent's Edcetion *(Specify only highest grade completed)*: Elementery/Secondery (0-12): 6 / College (1-4or 5+):

16a. Decedent's Usuel Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Homemaker

16b. Kind of Business/Industry: At Home

17. Father's Neme *(First, Middle, Last)*: William Risko

18. Mother's Neme *(First, Middle, Meiden Surneme)*: Anna Chabra

19a. Informent's Neme/Reletionship *(Type, Print)*: James Rison / Son

19b. Mailing Address *(Street end Number or Rural Route Number, City or Town, Stete, Zip Code)*: P.O.Box 145 Ironsides, Maryland 20643

20a. Method of Disposition: 1☒ Buriel 2☐ Cremetion 3☐ Removel from Stete 4☐ Donetion 5☐ Other *(Specify)*

20b. Piece of Disposition *(Neme of cemetery, cremetory or other place)*: Old Durham Ch. Cem.

Dete: March 20,2001

20c. Location - City or Town, Stete: Ironsides, MD

21. Signature of Funeral Service Licensee: [signature] M00641

22. Name end Address of Feclility: Arehart-Echols Funl.Hme,P.A. 211 St.Mary's Ave.LaPlata, MD 20646

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cerdiac or respiratory errest, shock, or heart failure. List only one cause on each line.

Approximete Intervel Between Onset end Death

Immediete Ceuse (Final disease or condition resulting in deeth)

a. Failure to thrive

Due to (or as a consequence of):

Sequentially list conditions, if any, leeding to immediete cause. Enter Underlying Cause (Disease or Injury thet initieted events resulting in deeth) Last

b. Dementia.

Due to (or as e consequence of):

c.

Due to (or es a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Wes an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings eveilable prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medicel examiner? 1☐ Yes 2☒ No

26. Place of Deeth *(Check only one)*: Hospitel: 1☐ Inpetient 2☐ ER/Outpetient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Menner of Deeth: 1☒ Netural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined

28a. Dete of Injury *(Month, Dey Yeer)*

28b. Time of Injury M

28c. Injury et Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Piece of Injury - At home, farm, street, fectory, office building, etc. *(Specify)*

28f. Location *(Street end Number or Rural Route Number, City or Town, Stete)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, dete end plece, and due to the ceuse(s) end manner as stated. 2☐ **Medical Examiner:** On the basis of examinetion and/or investigetion, in my opinion, deeth occurred et the time, dete end place, and due to the cause(s) and manner steted.

29b. Signeture and title of certifier: [signature]

29c. License number: D0046241

29d. Dete signed *(Month, Dey, Yeer)*: 3/21/01.

30. Neme and address of person who completed cause of death (Item 23a) (Type, Print): ROMAN DeSOUZA MD 4801 Kenmore Ave Suite 102 Alexandria VA 22304

State Registrar

31. Dete filed *(Month, Dey, Yeer)*: MAR 26 2001

32. Registrer's Signeture: G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 10232

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Mary Harriet Rippeon

2. Date of Death: Month March, Day 15, Year 2001

3. Time of Death: 10:15 PM

4a. Facility Name (If not institution, give street and number): Continuum Care at Sykesville

4b. City, Town, or Location of Death: Sykesville

4c. County of Death: Carroll

Funeral Director

5. Social Security Number: 181-07-7824

6. Sex: 1☐M 2☒F

7. Age (In yrs. last birthday): 86 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Dec. 8, 1914

9. Birthplace (State or Foreign Country): Pennsylvania

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: Maryland

10b. County: Carroll

10c. City, Town or Location: Sykesville

10d. Inside City Limits: 1☒Yes 2☐No

10e. Street and Number: 7309 Second Ave

10f. Zip Code: 21784

10g. Citizen of What Country? U.S.A.

11. Marital Status: 1☐Never Married 2☐Married 3☒Widowed 4☐Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐Yes 2☒No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 11; College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Weaver

18b. Kind of Business/Industry: Silk Factory

17. Father's Name (First, Middle, Last): Charles D. Crawn

18. Mother's Name (First, Middle, Maiden Surname): Laura Bellows

19a. Informant's Name/Relationship (Type, Print): Margaret A. Rill/daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 416 Baldwin Park Dr. Westminster, MD 21157

20a. Method of Disposition: 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Mt. Union Cemetery

Date: 3/19/2001

20c. Location - City or Town, State: Union Bridge, MD

21. Signature of Funeral Service Licensee: Catharine O. Hartzler

22. Name and Address of Facility: Hartzler Funeral Home, 310 Church St. New Windsor, MD 21776

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Atherosclerotic Coronary Vascular Disease — 15 yrs

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1☐Yes 2☑No 9☐Unknown

23c. If yes, outcome of pregnancy: 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown

23d. Date of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Diabetes Mellitus

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☑No 3☐Probably 4☐Unknown

24a. Was an autopsy performed? 1☐Yes 2☑No

24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☐No

Medical Certification; To Be Completed by Physician/Medical Examiner

25. Was case referred to medical examiner? 1☐Yes 2☑No

28. Place of Death (Check only one): Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☑Nursing Home 5☐Residence 8☐Other (Specify)

27. Manner of Death: 1☑Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐Yes 2☐No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Robert L. Moss, MD

29c. License number: D32882

29d. Date signed (Month, Day, Year): 3/17/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Robert C. Moss 114 Business Center Dr. Reisterstown, Md 21136

State Registrar

31. Date filed (Month, Day, Year): MAR 2 0 2001

32. Registrar's Signature: Geneva G Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

WJL 2

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 10233

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: BESSIE VIOLA RAINES

2. Date of Death — Month: MARCH; Day: 18; Year: 2001

3. Time of Death: 13:05

4a. Facility Name *(If not institution, give street and number)*: MEMORIAL HOSPITAL & MEDICAL CENTER

4b. City, Town, or Location of Death: CUMBERLAND

4c. County of Death: ALLEGANY

Funeral Director

5. Social Security Number: 215-42-4852

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 90 Yrs.

If Under 1 Year — Months: ; Days:

If Under 24 Hrs. — Hours: ; Min.:

8. Date of Birth *(Month, Day, Year)*: SEPT 11 1910

9. Birthplace *(State or Foreign Country)*: PA.

Usual Residence of Decedent

10a. State: MARYLAND

10b. County: ALLEGANY

10c. City, Town or Location: CUMBERLAND

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: PLEASANT VALLEY ROAD N.E.

10f. Zip Code: 21530

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* WHITE

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 8; College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: HOME MAKER

16b. Kind of Business/Industry: HOME MAKER

17. Father's Name *(First, Middle, Last)*: EDWARD JOSEPH HARDMAN

18. Mother's Name *(First, Middle, Maiden Surname)*: ALICE ARENTHA MANN

19a. Informant's Name/Relationship *(Type, Print)*: JANICE KANE DAUGHTER

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 13900 PLEASANT VALLEY ROAD N.E. CUMBERLAND MD 21530

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: SUNSET CEMETERY

Date: MARCH 21 2001

20c. Location - City or Town, State: CUMBERLAND MARYLAND

21. Signature of Funeral Service Licensee: Dale L. Merritt

22. Name and Address of Facility: MERRITT-ADAMS FUNERAL HOME P.A. 404 DECATUR STREET CUMBERLAND MARYLAND

Physician /Medical Examiner

23a. Part I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. CONGESTIVE HEART FAILURE — 2 WEEKS

Due to (or as a consequence of):

b. CORONARY ARTERY DISEASE — 3 YEARS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier:

29c. License number: D36766

29d. Date signed *(Month, Day, Year)*: MARCH 19, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): DR. VIK POONAI, SETON DRIVE, CUMBERLAND, MD 21502

State Registrar

31. Date filed *(Month, Day, Year)*: MAR 20 2001

32. Registrar's Signature: G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If Item 27 is marked other than "natural", or Items 23a or 28d-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

BESSIE RAINES 215-42-4852
Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

2

MS

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 10234

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
John Frederick Ross	March 18 2001	9:40 A. M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Sacred Heart Hospital	Cumberland	Allegany

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year Months	Days	If Under 24 Hrs. Hours	Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
215-18-8887	1 [X] M 2 [ ] F	87 Yrs.					May 17, 1913	Maryland

To Be Completed by Funeral Director

Usual Residence of Decedent

10e. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Allegany	Frostburg	1 [X] Yes 2 [ ] No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
One Kaylor Circle	21532	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces? If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced	1 [X] Yes 2 [ ] No 1942	1 [ ] Yes 2 [X] No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	18b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
7		Labor	Highways

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
John Ross	Laura Beeman

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Linda Robertson-Daughter	12209 Old Legislative Rd. S.W., Frostburg, Md. 21532

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	Restlawn Memorial Park	March 21, 2001	LaVale, Maryland

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ [signature]	Eichhorn-McKenzie Funeral Home P.A., Lonaconing Md. 21539

Physician /Medical Examiner

Medical Certification; To Be Completed by Physician/Medical Examiner

23e. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	e. Ruptured abdominal Aortic Aneurysm.	24 hours
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of): b. arteriosclerosis	40 years
	Due to (or as a consequence of): c.	
	Due to (or as a consequence of): d.	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month Day Year
1 [ ] Yes 2 [ ] No 9 [ ] Unknown	1 [ ] Live birth 2 [ ] Fetal death 3 [ ] Ectopic pregnancy 4 [ ] Pregnant at time of death 5 [ ] Other (specify) 9 [ ] Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Dementia Hypertension

Hypothyroidism.

23e. Did tobacco use contribute to the cause of death?	24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown	1 [ ] Yes 2 [X] No	1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1 [ ] Yes 2 [X] No	Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA	Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined		M	1 [ ] Yes 2 [ ] No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ S L Sandhir M D	D 14464	MARCH 19 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DR SIKANDER SANDHIR - 48 TARN TERRACE, FROSTBURG, MD 21532

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
MAR 20 2001	[signature]

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

2

MLS

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 10235

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)			2. Date of Death Month / Day / Year	3. Time of Death
PAULINE AGNES RAINES			March 22 2001	7:20 A M
4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death		
SACRED HEART HOSPITAL	CUMBERLAND	ALLEGANY		

Funeral Director

5. Social Security Number	8. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	6. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
214-07-3087	1☐M 2☒F	85 Yrs.			JULY 18 1915	MARYLAND

Usual Residence of Decedent

10e. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MARYLAND	ALLEGANY	CUMBERLAND	1☐Yes 2☒No

10e. Street and Number	10f. Zip Code	10g. Citizen of Whet Country?
10906 MASON ROAD N.E.	21502	U.S.A.

11. Merital Stetus	12. Wes Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Bleck, White, etc.
1☐Never Married 2☒Married 3☐Widowed 4☐Divorced	1☐Yes 2☒No If Yes, Give Year or Detes:	1☐Yes 2☒No Specify:	Specify: WHITE

15. Decedent's Education (Specify only highest grede completed)		16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementery/Secondary (0-12)	College (1-4or 5+)		
6		CELANESE CORP OF AMERICA	SILK MANUF.

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Meiden Surname)
SAMUEL WILSON	ELIZABETH ADELINE TWIGG

19a. Informant's Neme/Relationship (Type, Print)	19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
JOHN RAINES HUSBAND	10906 MASON ROAD N.E. CUMBERLAND MARYLAND 21502

20e. Method of Disposition	20b. Piece of Disposition (Name of cemetery, cremetory or other piece) / Dete	20c. Location - City or Town, Stete
1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	HILLCREST CEMETERY MARCH 25 2001	CUMBERLAND MARYLAND

21. Signature of Funeral Service Licensee	22. Name end Address of Facility
▶ Dale L. Merritt	MERRITT-ADAMS FUNERAL HOME P.A. 404 DECATUR STREET CUMBERLAND MARYLAND

Physician /Medical Examiner

23a. Pert1. Enter the diseese, or complications thet caused the death. Do not enter the mode of dying, such es cardiac or respiratory errest, shock, or heert failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Finel disease or condition resulting in deeth)	a. Pneumonia	5 days
Sequentially list conditions, if eny, leeding to immediete cause. Enter Underlying Cause (Disease or injury thet initiated events resulting in death) Last	Due to (or as a consequence of): b.	
	Due to (or es a consequenca of): c.	
	Due to (or as e consequenca of): d.	

IF FEMALE: 23b. Wes decedent pregnent in the past 12 months?	23c. If yes, outcome of pregnency	23d. Data of delivary Month / Day / Year
1☐Yes 2☒No 9☐Unknown	1☐Live birth 2☐Fetel death 3☐Ectopic pregnency 4☐Pregnent et time of deeth 5☐Other (specify) 9☐Unknown	

Pert II. **Othar significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Alzheimers Disease

Congestive Heart Failure

23e. Did tobecco use contribute to the cause of death?	24e. Was en autopsy performed?	24b. Were autopsy findings available prior to completion of cause of deeth?
1☐Yes 2☒No 3☐Probably 4☐Unknown	1☐Yes 2☒No	1☐Yes 2☐No

25. Wes case referred to medical examiner?	28. Place of Death (Check only one)	
1☐Yes 2☒No	Hospitel: 1☒Inpatient 2☐ER/Outpatient 3☐DOA	Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Menner of Deeth	28a. Date of Injury (Month, Dey Yeer)	28b. Time of Injury	28c. Injury et Work?	28d. Describe how injury occurred
1☒Naturel 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined		M	1☐Yes 2☐No	
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rurel Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one) 1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, dete end placa, end due to the cause(s) end menner es steted. 2☐**Medical Examiner:** On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date end place, end due to tha cause(s) and manner stated.

29b. Signature and title of certifier	29c. Licanse number	29d. Date signed (Month, Dey, Year)
▶ MD	D35135	March 23 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Thomas E. Chapell MD 912 Seton Dr. Cumberland MD

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
MAR 26 2001	▶ Brenda B Sparks

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'naturel', or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

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WS

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 10236

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): ANTHONY JOHN RUSSELL, JR.
2. Date of Death (Month, Day, Year): March 23 2001
3. Time of Death: 9:00 A M
4a. Facility Name (If not institution, give street and number): SACRED HEART HOSPITAL
4b. City, Town, or Location of Death: CUMBERLAND
4c. County of Death: ALLEGANY

Funeral Director

5. Social Security Number: 220-16-5457
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 75 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): AUG 6, 1925
9. Birthplace (State or Foreign Country): MARYLAND

Usual Residence of Decedent

10a. State: MARYLAND
10b. County: ALLEGANY
10c. City, Town or Location: LAVALE
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 1075 NATIONAL H WY
10f. Zip Code: 21502
10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Rece - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 8 / College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): SPINNING DEPT
16b. Kind of Business/Industry: FIBER/TEXTILE

17. Father's Name (First, Middle, Last): ANTHONY JOHN RUSSELL
18. Mother's Name (First, Middle, Maiden Surname): MARY ANNA TALLEY

19a. Informant's Name/Relationship (Type, Print): SHIRLEY RUSSELL-WIFE
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1075 NATIONAL HWY, LAVALE, MD 21502

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): HILLCREST MEMORIAL PARK
Date: MAR 26, 2001
20c. Location - City or Town, State: CUMBERLAND, MD

21. Signature of Funeral Service Licensee: Douglas S Hafer
22. Name and Address of Facility: HAFER CHAPEL OF THE HILLS MORTUARY 1302 NATIONAL HWY, LAVALE, MD 21502

Physician /Medical Examiner

23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. CONGESTIVE HEART FAILURE — ONE DAY

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
b. DILATED CARDIOMYOPATHY — TEN YEARS
Due to (or as a consequence of):
c.
Due to (or as e consequence of):
d.

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1 [ ] Yes 2 [ ] No 9 [ ] Unknown
23c. If yes, outcome of pregnancy: 1 [ ] Live birth 2 [ ] Fetal death 3 [ ] Ectopic pregnancy 4 [ ] Pregnant at time of death 5 [ ] Other (specify) 9 [ ] Unknown
23d. Date of delivery: Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
SEPSIS
CEREBRAL HEMORRHAGE

23e. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No
26. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification; To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1 [X] Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: MD
29c. License number: D33417 (MD.)
29d. Date signed (Month, Day, Year): March 26, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): JAMES R. MOEN, M.D. 1068 NATIONAL HIGHWAY LAVALE, MARYLAND 21502

State Registrar

31. Date filed (Month, Day, Year): MAR 26 2001
32. Registrar's Signature: Penny D Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 10237

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Cordy Belle Brooks Schaible

2. Date of Death Month / Day / Year: March 17, 2001

3. Time of Death: 9:05pm

4a. Facility Name *(If not institution, give street and number)*: 505 Congress Ave. Apt. 403

4b. City, Town, or Location of Death: Havre de Grace

4c. County of Death: Harford

Funeral Director

5. Social Security Number: 214-26-8057

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 71 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: 06/05/1929

9. Birthplace *(State or Foreign Country)*: North Carolina

Usual Residence of Decedent

10a. State: MD

10b. County: Harford

10c. City, Town or Location: Havre de Grace

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 505 Congress Ave. Apt. 403

10f. Zip Code: 21078

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementery/Secondery (0-12): 3rd; College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Homemaker

16b. Kind of Business/Industry: Home

17. Father's Name *(First, Middle, Last)*: Philo Freel Caudill

18. Mother's Name *(First, Middle, Maiden Surname)*: Loucrita Holbrook

19a. Informant's Name/Relationship *(Type, Print)*: Laura Brooks- Daughter

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 1464 Primrose Rd., Belcamp, MD 21017

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: R.A. Ferris & Co. Inc.

Date: 3/19/01

20c. Location - City or Town, State: West Chester, PA

21. Signature of Funeral Service Licensee: Elaine M. Smith

22. Name and Address of Facility: Mitchell-Smith Funeral Home, P.A. 123 S. Washington, Havre de Grace, MD 21078

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one ceuse on eech line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Lymphoma

Due to (or as a consequenca of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b.

Due to (or as a consequenca of):

c.

Due to (or as a consequenca of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the ceuse of death? 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death *(Check only one)*: Hospitel: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☑ Residence 8☐ Other *(Specify)*

27. Manner of Death: 1☑ Neturat 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Data of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier *(Check only one)*: 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner es steted. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and pleca, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Mishp Sim

29c. License number: D4641

29d. Date signed *(Month, Day, Year)*: 3/19/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Mishp Sim 319 S. Union Ave Hdg MD 21093

State Registrar

31. Date filed *(Month, Day, Year)*: MAR 20 2001

32. Registrar's Signature: B. Sparks

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 10238

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): John Edmund Smith
2. Date of Death Month: 3 Day: 19 Year: 01
3. Time of Death: 1704
4a. Facility Name (If not Institution, give street and number): 200 W. FAIRFIELD DR.
4b. City, Town, or Location of Death: SALISBURY
4c. County of Death: WICOMICO

Funeral Director

5. Social Security Number: 213-24-1121
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 70 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): JULY 10, 1930
9. Birthplace (State or Foreign Country): MARYLAND

Usual Residence of Decedent

10a. State: MARYLAND
10b. County: WICOMICO
10c. City, Town or Location: SALISBURY
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 200 W. FAIRFIELD DR
10f. Zip Code: 21804
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: NAVY
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 / College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): OWNER/OPERATOR
16b. Kind of Business/Industry: MECHANICAL CONTRACTOR

17. Father's Name (First, Middle, Last): TROWBRIDGE E. SMITH
18. Mother's Name (First, Middle, Maiden Surname): LELIA TOWNSEND

19a. Informant's Name/Relationship (Type, Print): LOIS T. SMITH - WIFE
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 200 W. FAIRFIELD DR. SALISBURY, MD 21804

20a. Method of Disposition: 1 [ ] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [X] Other (Specify) entombment
20b. Place of Disposition (Name of cemetery, cremetory or other place): PARSONS CEMETERY
Date: 3/22/01
20c. Location - City or Town, State: SALISBURY, MARYLAND

21. Signature of Funeral Service Licensee: ▶ Melissa Ann Hey
22. Name and Address of Facility: 705 E. MAIN ST. BOUNDS FUNERAL HOME, INC. SALISBURY, MD 21804

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Astrocytoma — 1 year
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No
26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify)
27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: ▶ Roger C Merrill MD
29c. License number: D21953
29d. Date signed (Month, Day, Year): 3/19/01
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Roger C. Merrill MD

State Registrar

31. Data filed (Month, Day, Year): MAR 2 1 2001
32. Registrar's Signature: ▶ Brenda B Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

5 DQ

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 10239

Frieda Schoenstein SS# 131-09-1846

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

Physician /Medical Examiner

Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

1. Decedent's Name (First, Middle, Last)			2. Date of Death (Month, Day, Year)		3. Time of Death
FRIEDA		SCHOENSTEIN	March 16, 2001		0950 M
4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Location of Death		4c. County of Death	
PENINSULA REGIONAL MEDICAL CENTER		SALISBURY		WICOMICO	
5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
131-09-1846	1☐M 2☒F	96 Yrs.		February 12, 1905	Germany

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Wicomico	Salisbury	1☐Yes 2☒No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
8068 West Road	21801	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐Never Married 2☐Married 3☒Widowed 4☐Divorced	1☐Yes 2☒No If Yes, Give Year or Dates:	1☐Yes 2☒No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12	–	Homemaker	Domestic

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
John Rosch	Maria Ertl

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Diane A. Adamovich/Daughter	8068 West Rd., Salisbury, MD 21801

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☐Burial 2☒Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	Salisbury Crematory	3/20/01	Salisbury, Maryland

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
David A. Thompson MD1051	Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804

Medical Certification; To Be Completed by Physician/Medical Examiner

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one ceuse on each line.

		Approximate Interval Between Onset and Death
Immediate Ceuse (Finel disease or condition resulting in death)	a. Rectal cancer	yrs
Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as e consequence of): b. [illegible]	days
	Due to (or as a consequence of): c. Dementia	yrs
	Due to (or as a consequence of): d.	

IF FEMALE: 23b. Was decedent pregnant in the pest 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery (Month, Day, Year)
1☐Yes 2☐No 9☐Unknown	1☐Live birth 2☐Fetel death 3☐Ectopic pregnancy 4☐Pregnent at time of death 5☐Other (specify) 9☐Unknown	

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobecco use contribute to the cause of death?	24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐Yes 2☒No 3☐Probably 4☐Unknown	1☐Yes 2☒No	1☐Yes 2☐No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐Yes 2☒No	Hospital: 1☑Inpatient 2☐ER/Outpatient 3☐DOA	Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☑Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined		M	1☐Yes 2☐No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
[signature]	029749	3/16/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Dr. William Robins 1104 Healthway Drive, Salisbury Md. 21804

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
MAR 19 2001	[signature] Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 10240

ISABELLE SWEITZER 218-48-7590

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

Physician /Medical Examiner

Funeral Director

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

1. Decedent's Name (First, Middle, Last): Isabell M. Sweitzer		2. Date of Death: Month 3 Day 16 Year 2001	3. Time of Death: 9:25 am
4a. Facility Name (If not institution, give street and number): MEMORIAL HOSPITAL	4b. City, Town, or Location of Death: CUMBERLAND	4c. County of Death: ALLEGANY	
5. Social Security Number: 218-48-7590	6. Sex: 1☐M 2☒F	7. Age (In yrs. last birthday): 93 Yrs. (If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.)	8. Date of Birth (Month, Day, Year): Aug 28, 1907
9. Birthplace (State or Foreign Country): MD			

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits, 1☒Yes 2☐No
MD	Allegany	Cumberland	

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
809 Michigan Avenue	21502	USA

11. Marital Status	12. Wes Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐Never Married 2☐Married 3☒Widowed 4☐Divorced	1☐Yes 2☒No If Yes, Give Year or Dates:	1☐Yes 2☒No Specify:	Specify: white

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12): 12	College (1-4or 5+):	homemaker	own home

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Andrew H. Smith	Kattarn (Wellen)

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Andrew R. Sweitzer SON	20505 Andy's Lane;Flintstone MD 21530

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, Stete
1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	Hillcrest Memorial Par	3/19/2001	Cumberland, MD

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ Nicholas J. Scarpelli	Scarpelli Funeral Home, P.A. Cumberland, MD 21502

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediete Ceuse (Finel disease or condition resulting In death)

a. Cardiomyopathy — 3 years

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or es e consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☒Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐Yes 2☒No	1☐Yes 2☐No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐Yes 2☒No	Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA	Other: 4☐Nursing Homa 5☐Residence 6☐Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined		M	1☐Yes 2☐No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signeture end title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶	D36766	MARCH 3 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DR. VIK POONAI 924 SETON DRIVE CUMBERLAND, MD 21502

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

FD Nah

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
MAR 19 2001	▶ Geneva B Sparks

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 10241

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): LOUISE RUTH STURTZ

2. Date of Death (Month, Day, Year): March 23, 2001

3. Time of Death: 10:16 PM

4a. Facility Name (If not institution, give street and number): Devlin Manor Nursing Home

4b. City, Town, or Location of Death: Cumberland

4c. County of Death: Allegany

Funeral Director

5. Social Security Number: 193 18 2052

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 88 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): 10-31-1912

9. Birthplace (State or Foreign Country): PA

Usual Residence of Decedent

10a. State: MD

10b. County: Allegany

10c. City, Town or Location: Cumberland

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 10301 Christie Road

10f. Zip Code: 21502

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Laborer

16b. Kind of Business/Industry: Manufacturing

17. Father's Name (First, Middle, Last): William Lawrence Horner

18. Mother's Name (First, Middle, Maiden Surname): Savilla Ellen Croyle

19a. Informant's Name/Relationship (Type, Print): Virginia Walls, daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4724 Bedford Valley Road, Bedford, PA 15522

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☒ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, cremetory or other place): Thomas Mennonite Cemet. | Date: 3-27-01

20c. Location - City or Town, State: Davidsville, PA

21. Signature of Funeral Service Licensee: ▶ Harvey H Zeigler

22. Name and Address of Facility: Harvey H. Zeigler Funeral Home, 169 Clarence Street, Hyndman, PA

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) a.	RENAL FAILURE, CHRONIC	ONE YR
Due to (or as a consequence of): b.	NEPHROSCLEROSIS	FIVE YR
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last: Due to (or as a consequence of): c.		
Due to (or as a consequence of): d.		

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day, Year) | 28b. Time of Injury | 28c. Injury at Work? 1☐ Yes 2☐ No | 28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Robustiano J. Barrera, Jr.

29c. License number: D-14865

29d. Date signed (Month, Day, Year): MAR. 26TH, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): ROBUSTIANO BARRERA MEMORIAL HOSP. MED. BLDG. CUMBERLAND, MARYLAND

State Registrar

31. Date filed (Month, Day, Year): MAR 26 2001

32. Registrar's Signature: ▶ [signature]

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

Amended #26, MRS 3/28/01, Allegany Co.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 10242

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Thomas C. Stakem
2. Date of Death: Month 3 Day 21 Year 01
3. Time of Death: 9:45 P.M.
4a. Facility Name (If not Institution, give street and number): 14816 Paradise St. S.W.
4b. City, Town, or Location of Death: Frostburg
4c. County of Death: Allegany

Funeral Director

5. Social Security Number: 214-07-4142
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 84 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): August 20, 1916
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Allegany
10c. City, Town or Location: Frostburg
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 14816 Paradise St.,S.W
10f. Zip Code: 21532
10g. Citizen of What Country? USA

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: 1943
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 — College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Labor
16b. Kind of Business/Industry: Paper

17. Father's Name (First, Middle, Last): James B. Stakem
18. Mother's Name (First, Middle, Maiden Surname): Teresa Sharpe

19a. Informant's Name/Relationship (Type, Print): Mary Jane Stakem-Daughter
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 812 Edgewood Drive,Cumberland,Md. 21502

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): St. Josephs Cemetery — Date: March 26, 2001
20c. Location - City or Town, State: Midland,Md.

21. Signature of Funeral Service Licensee: Jane C. McKee
22. Name and Address of Facility: Eichhorn-McKenzie Funeral Home P.A.,Lonaconing,Md. 21539

Physician /Medical Examiner

23a. Part I. Enter the disease, or conditions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. congestive Heart Failure — years
Due to (or as a consequence of):
b. atrial fibrillation — months

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c. Coronary disease
Due to (or as a consequence of):
d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Diabetes

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No
26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [X] ER/Outpatient 3 [ ] DOA — Other: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify)
27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated. 2 [ ] Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: R. Espina, MD
29c. License number: D03459
29d. Date signed (Month, Day, Year): 3/22/01
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): R. ESPINA, MD 902 Seton Drive Cumberland Md

State Registrar

31. Date filed (Month, Day, Year): MAR 23 2001
32. Registrar's Signature: [illegible]

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

9 MRS

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 10243

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): MABEL A. TAHANEY
2. Date of Death (Month, Day, Year): March 19, 2001
3. Time of Death: 1:00 AM
4a. Facility Name (If not institution, give street and number): Glen Meadows Retirement Community
4b. City, Town, or Location of Death: Glen Arm
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 218-18-1269
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 95 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 11/9/1905
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: MD.
10b. County: Harford
10c. City, Town or Location: Pylesville
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 2400 Rocks Road
10f. Zip Code: 21132
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: Caucasian

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 9 | College (1-4or 5+): 0
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Housewife
16b. Kind of Business/Industry: Home

17. Father's Name (First, Middle, Last): Francis A. Kearney
18. Mother's Name (First, Middle, Maiden Surname): Emma V. Smith

19a. Informant's Name/Relationship (Type, Print): Mary M. Crummitt / Niece
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2715 Woodedge Rd. Silver Spring, Md. 20906

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): St. John Cemetery
Date: 3/23/2001
20c. Location - City or Town, State: Hydes, Maryland

21. Signature of Funeral Service Licensee: M. Gladden Kurtz III
22. Name and Address of Facility: E.G. Kurtz & Son Funeral Home, P.A. Jarrettsville, Maryland

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. MULTI-INFARCT DEMENTIA — 2 yrs

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: HYPERTENSION

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☑ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: M. Dalby MD
29c. License number: D30433
29d. Date signed (Month, Day, Year): 3/20/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): M DALY, 90 GBMC 6701 N CHARLES ST BALTIMORE MD 21204

State Registrar

31. Date filed (Month, Day, Year): MAR 21 2001
32. Registrar's Signature: Donna D. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than 'natural', or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 10244

Irene Toadvine

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)			2. Date of Death Month Day Year	3. Time of Death
IRENE	LAWS	TOADVINE	March 19 2001	1:05a.m.

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Wicomico Nursing Home	Salisbury	Wicomico

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year Months	If Under 1 Year Days	If Under 24 Hrs. Hours	If Under 24 Hrs. Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
213-42-0805	1☐M 2☒F	98 Yrs.					August 3,1902	Maryland

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Wicomico	Willards	1☐Yes 2☒No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
35275 Cobbs Hill Road	21874	USA

11. Marital Status	12. Was Decedent Evar in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, atc.)	14. Race - American Indian, Black, White, atc.
1☐Nevar Marriad 2☐Married 3☒Widowed 4☐Divorced	1☐Yes 2☒No If Yes, Give Yaar or Dates:	1☐Yes 2☒No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completad)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	Collega (1-4or 5+)		
11	1	Homemaker	Domestic

17. Father's Nama (First, Middle, Last)	18. Mother's Name (First, Middle, Maidan Surname)
James Handy Laws	Leah Catherine Jarmon

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Leah T. Rayne/Daughter	35275 Cobbs Hill Rd., Willards, Md 21874

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	Parsons Cemetery	3/22/01	Salisbury, MD

21. Signature of Funaral Service Licensee	22. Nama and Address of Facility
▶ Kell R Lowey CFSP	Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part1. Enter the disease, or complications that caused tha daath. Do not antar tha moda of dying, such as cardiac or respiratory arrest, shock, or haart tailura. List only ona cause on aach lina.

		Approximate Interval Between Onset and Death
Immediata Causa (Final disaasa or condition resulting in death) a.	POOR ORAL INTAKE	3 WEEKS
Dua to (or as a consequence of): b.	ADVANCED DEMENTIA	YEARS.
Sequantially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last — Dua to (or as a consequenca of): c.		
Dua to (or as a consequance of): d.		

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

RENAL INSUFFICIENCY

ATRIAL FIBRILLATION

23b. Did tobacco use contribute to the cause of death?	24a. Was an autopsy performed?	24b. Ware autopsy findings available prior to completion of cause of death?
1☐Yes 2☑No 3☐Probably 4☐Unknown	1☐Yes 2☑No	1☐Yes 2☐No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐Yes 2☑No	Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA	Other: 4☑Nursing Home 5☐Rasidenca 6☐Othar (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Tima of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☐Natural 2☐Accident 3☐Suicida 4☐Homicida 5☐Pending investigation 6☐Could not be datarmined		M	1☐Yes 2☐No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1☐ **Certifying Physician:** To the best of my knowledge, daath occurred at the time, date and place, and due to tha causa(s) and mannar as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, daath occurred at tha time, date and place, and due to tha cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ MOHAN BHATT, MD	D0055O6	MARCH 19, 2001

30. Name and address of parson who completed cause of death (Item 23a) (Type, Print)
MOHAN BHATT, MD 614B EASTERN SHORE DR., SALISBURY, MD

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

BQ

State Registrar

31. Data filed (Month, Day, Year)	32. Registrar's Signature
MAR 21 2001	▶ Denise G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

1- For State Registrar

Reg. No. 2001 10245

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
LeRoy Turner	March 18, 2001	1952 M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
PENINSULA REGIONAL MEDICAL CENTER	SALISBURY	WICOMICO

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
214-46-4537	1☒M 2☐F	55 Yrs.			Sept 19, 1945	MD

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	Wicomico	Nanticoke	1☐Yes 2☒No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
2776 Turner Lane	21840	U.S.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐Never Married 2☒Married 3☐Widowed 4☐Divorced	1☐Yes 2☒No If Yes, Give Year or Dates:	1☐Yes 2☒No Specify:	Specify: Black

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	18b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12		Foreman	Construction

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Samuel Turner	Inez Nutter

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Patricia Turner/wife	2776 Turner Lane, P. O. Box 57, Nanticoke, MD 21840

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	Asbury UMC Cemetery	3/24/2001	Nanticoke, MD

21. Signature of Funeral Service Licensee ▶ [signature]

22. Name and Address of Facility: Lewis N. Watson Funeral Home, 1618 West Rd., Salisbury, MD 21801

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Physician /Medical Examiner

Medical Certification; To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errast, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. ASYSTOLE	2 DAYS
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of): b. INTRACEREBRAL/INTRACRANIAL HYPERTENSION	MINUTES
	Due to (or as a consequence of): c. INTRACEREBRAL HEMORRHAGE	YEARS
	Due to (or as a consequence of): d. ARTERIOVENOUS MALFORMATION	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month Day Year
1☐Yes 2☐No 9☐Unknown	1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying causa given in Part I.

23a. Did tobacco use contribute to the causa of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐Yes 2☒No	1☐Yes 2☐No

25. Was case referred to medical examiner?	28. Place of Death (Check only one)
1☐Yes 2☒No	Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined		M	1☐Yes 2☐No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ [signature] TUNG T. NGUYEN, MD	MD D0054621	MARCH 18 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): TUNG T. NGUYEN, MD 560 RIVERSIDE DR SUITE A102 SALISBURY MD 21801

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
MAR 21 2001	▶ [signature]

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 | 0246

THELMA TWIGG 219-46-2057

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)			2. Date of Death Month	Day	Year	3. Time of Death
Thelma	Martha	Twigg	3	16	2001	8:16 am

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
MEMORIAL HOSPITAL	CUMBERLAND	ALLEGANY

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months	Days	If Under 24 Hrs.: Hours	Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
219-46-2057	1☐ M 2☒ F	81 Yrs.					Jul 10, 1919	WV

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	Allegany	Cumberland	1☒ Yes 2☐ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
13007 Azalea Lane	21502	USA

11. Meritel Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indien, Black, White, etc.
1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced	1☐ Yes 2☒ No If Yes, Give Year or Dates:	1☐ Yes 2☒ No Specify:	Specify: white

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12		Homemaker	Own Home

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Price Evans	Almeda (Smith)

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Eva May Twigg daughter-in-law	2616 Wycliffe Road;Baltimore MD 21234

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)	Sunset Memorial Park	3/21/2001	Cumberland, MD

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ Nicholas J Scarpelli	Scarpelli Funeral Home, P.A. Cumberland, MD 21502

To Be Completed by Funeral Director

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediete Cause (Final disease or condition resulting in death)	a. Cardiomyopathy	5 years
	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	b. Congestive Heart Failure	3 years
	Due to (or as a consequenca of):	
	c.	
	Due to (or as a consequenca of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐ Yes 2☒ No	1☐ Yes 2☐ No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐ Yes 2☒ No	Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA	Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined		M	1☐ Yes 2☐ No	
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one)	29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
1☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.	▶	D36766	MARCH 16, 2001

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Division of Vital Records, P.O. Box 68760,

(5) not

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
DR VIK POONAI 924 SETON DRIVE CUMBERLAND, MD 21502

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
MAR 19 2001	▶

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

Amend Item 23a. Part I. b per Physician, 03/21/2001, Carroll County wjl

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No: 2001 10247

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): NANCY R. TAWNEY

2. Date of Death Month: MAR Day: 15 Year: 2001

3. Time of Death: 9:25AM

4a. Facility Name (If not institution, give street and number): Ruxton Health & Rehabilitation Ctr

4b. City, Town, or Location of Death: Pikesville

4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 212-20-9542

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 91 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Sep 2, 1909

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Carroll

10c. City, Town or Location: Manchester

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 3257 Main Street

10f. Zip Code: 21102

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: white

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 6 | College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Housewife

16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): John A. Lloyd, Sr

18. Mother's Name (First, Middle, Maiden Surname): Bertie Brown

19a. Informant's Name/Relationship (Type, Print): Marilyn Howard, grandaughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 17 Delight Rd, Reisterstown, MD 21136

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Carroll Cremations

Date: 3/16 2001

20c. Location - City or Town, State: Hampstead, MD

21. Signature of Funeral Service Licensee: Steven L. Cline MD0723

22. Name and Address of Facility: Eline Funeral Home 934 South Main St. Hampstead, MD 21074

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 28a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiretory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Renal failure — 3weeks

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury thet Initieted events resulting in death) Last

b. Sepsis

Due to (or as a consequence of):

c.

Due to (or es a consequence of):

d.

Part II. **Other sfgnificant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Dementia

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☑ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☑ Nursing Home 5☐ Residance 6☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicida 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify)

28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the causa(s) and mannar as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the tima, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Elliot Rothschild md

29c. License number: D51426

29d. Date signed (Month, Day, Year): March 16, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Elliot Rothschild 4000 Old Court Rd, Pikesville, md 21208

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

WJL 3

State Registrar

31. Date filed (Month, Day, Year): MAR 2 1 2001

32. Registrar's Signature: Geneva G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 10248

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Cassandra Louisa Vaughn

2. Date of Death (Month, Day, Year): March 18, 2001

3. Time of Death: 11:00 PM

4e. Facility Name (If not institution, give street and number): 1506 Hillside Drive

4b. City, Town, or Location of Death: Bel Air

4c. County of Death: Harford

Funeral Director

5. Social Security Number: 219-03-0053

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 81 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Apr. 15, 1919

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Harford

10c. City, Town or Location: Bel Air

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 1506 Hillside Drive

10f. Zip Code: 21015

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker

16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): Frederick Stephen Lochary

16. Mother's Name (First, Middle, Maiden Surname): Clara Isabelle Poole

19a. Informant's Name/Relationship (Type, Print): Jeffrey L. Vaughn / Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 813 Thomas Run Road, Bel Air, MD 21015

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, cremetory or other place): Bel Air Memorial Gardens | Date: 3-23-01 | 20c. Location - City or Town, State: Bel Air, Maryland

21. Signature of Funeral Service Licensee: Stanley A Waugh

22. Name and Address of Facility: McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. endstage cardiac disease

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

history breast cancer

chronic pain syndrome

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

26b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

26d. Describe how injury occurred

26e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: David S Dunn

29c. License number: D32277

29d. Date signed (Month, Day, Year): March 17, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): DAVID S. DUNN 615 W. MacPhail

State Registrar

31. Date filed (Month, Day, Year): MAR 20 2001

32. Registrar's Signature: B. Sparks

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. **To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

12

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 10249

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Pearl Valentine
2. Date of Death: Month March Day 15 Year 2001
3. Time of Death: 3:00AM
4a. Facility Name (If not institution, give street and number): Westminster Nursing & Rehabilitative Ctr.
4b. City, Town, or Location of Death: Westminster
4c. County of Death: Carroll

Funeral Director

5. Social Security Number: 228-14-7453
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 80 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Dec. 15, 1920
9. Birthplace (State or Foreign Country): Virginia

Usual Residence of Decedent

10a. State: Maryland
10b. County: Frederick
10c. City, Town or Location: Union Bridge
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 13120 Good Intent Rd.
10f. Zip Code: 21791
10g. Citizen of What Country? U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 11 / College (1-4 or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): customer service
16b. Kind of Business/Industry: retail

17. Father's Name (First, Middle, Last): John Morris
18. Mother's Name (First, Middle, Maiden Surname): Elizabeth McConnel

19a. Informant's Name/Relationship (Type, Print): Roger E. Tompkins/ son
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 13120 Good Intent Rd. Union Bridge, MD 21791

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Parklawn Memorial Park
Date: 3/16/01
20c. Location - City or Town, State: Rockville, MD

21. Signature of Funeral Service Licensee: ▶ Catharine D. Hartzler
22. Name and Address of Facility: Hartzler Funeral Home, 6 E. Broadway Union Bridge, MD 21791

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) a.	CVA	1yr
Due to (or as a consequence of): b.	ASCVD	15yr
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last: Due to (or as a consequence of): c.		
Due to (or as a consequence of): d.		

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one)
Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA
Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ John W. Middleton
29c. License number: D25443
29d. Date signed (Month, Day, Year): 3-15-2001

30. Name and address of person who completed cause of death (Item 29a) (Type, Print): John W. Middleton 688 Poole Road, Westminster MD 21157

State Registrar

31. Date filed (Month, Day, Year): MAR 2 0 2001
32. Registrar's Signature: ▶ Geneva G Sparks

WSL 3

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 10250

170-10-9592

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Mary Vanston

2DQ

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)			2. Date of Death Month / Day / Year	3. Time of Death
MARY	BEATRICE	VANSTON	March 17, 2001	0055

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
PENINSULA REGIONAL MEDICAL CENTER	SALISBURY	WICOMICO

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
170-10-9592	1☐ M 2☒ F	85 Yrs.			AUG. 15, 1915	PENNSYLVANIA

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MARYLAND	WICOMICO	SALISBURY	1☒ Yes 2☐ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
148 FRANCIS DR	21804	U.S.A.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced	1☐ Yes 2☒ No If Yes, Give Year or Dates:	1☐ Yes 2☒ No Specify:	Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12		HOMEMAKER	OWN HOME

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
MICHAEL CONWAY	BRIDGET PHILBIN

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
MARY LOUISE BALISH - DAUGHTER	148 FRANCIS DR. SALISBURY, MD 21804

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)	CAMBRIDGE CREMATORY	3/18/01	CAMBRIDGE, MARYLAND

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
Melissa Kay Henry	705 E. MAIN ST. BOUNDS FUNERAL HOME, INC. SALISBURY, MD 21804

Physician /Medical Examiner

23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Pneumonia	
	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b.	
	Due to (or es e consequenca of):	
	c.	
	Due to (or as a consequence of):	
	d.	

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Urosepsis, Bacteremia
& Electrolyte Imbalance,
Essential Hypertension, Dementia

23b. Did tobacco use contribute to the cause of death?	24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown	1☐ Yes 2☒ No	1☐ Yes 2☐ No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐ Yes 2☒ No	Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA	Other: 4☐ Nursing Home 5☐ Residenca 6☐ Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined		M	1☐ Yes 2☐ No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signeture and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
	D37670	3/19/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. L. E. Evangelista 105 Pine Bluff Rd #4 Salisbury, MD 21801

State Registrar

31. Dete filed (Month, Day, Year)	32. Registrar's Signature
MAR 19 2001	G Sparks

DHMH 16 Rev 6/95

ORIGINAL

VOID

CERTIFICATE ⌘

01-10251

SEE

CERTIFICATE ⌘

00-34234

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 10252

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): JUNE FAYE WILSON

2. Date of Death (Month, Day, Year): MARCH 20, 2001

3. Time of Death: 0530

4a. Facility Name (If not institution, give street and number): PENINSULA REGIONAL MEDICAL CENTER

4b. City, Town, or Location of Death: SALISBURY

4c. County of Death: WICOMICO

Funeral Director

5. Social Security Number: 217-42-5171

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 58 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): JAN. 18, 1943

9. Birthplace (State or Foreign Country): MARYLAND

Usual Residence of Decedent

10a. State: DELAWARE

10b. County: SUSSEX

10c. City, Town or Location: LAUREL

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: BOX T 217

10f. Zip Code: 19956

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yeer or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indien, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 11 / College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): CERTIFIED NURSING ASSISTANCE

16b. Kind of Business/Industry: HOSPITAL

17. Father's Name (First, Middle, Last): WILLIAM HENRY BROWN, SR.

18. Mother's Name (First, Middle, Meiden Surname): HELEN MARGARET SALTCHER

19a. Informant's Neme/Relationship (Type, Print): LINDA D. SMITH /sister

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 31840 QUAIL RIDGE RD. SALISBURY, MD 21804

20a. Method of Disposition: 1☒ Buriel 2☐ Cremation 3☐ Removel from Stete 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, cremetory or other place): SPRINGHILL MEMORY GARDENS

Date: 3/23/01

20c. Location - City or Town, State: HEBRON, MARYLAND

21. Signature of Funeral Service Licensee: B. Keith Lloyd CFSP

22. Name and Address of Facility: BOUNDS FUNERAL HOME, INC. 705 E. MAIN ST. SALISBURY, MD 21804

Physician /Medical Examiner

23a. Part1. Enter the disease, or complicetions that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feilure. List only one cause on eech line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Chronic Renal Failure ~

Due to (or as a consequenca of): diabetic nephropatny

Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b. Due to (or as a consequence of): ~

c. Due to (or es e consequenca of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Afib

23b. Did tobacco use contribute to the ceuse of death? 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medicat axaminer? 1☐ Yes 2☑ No

28. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☑ Nursing Home 5☐ Residenca 6☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, deeth occurred at the time, date and placa, end due to the cause(s) and manner es stated. 2☐ **Medical Examiner:** On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) and menner stated.

29b. Signature and title of certifier: Clem Smith D.O.

29c. License number: H50497

29d. Date signed (Month, Day, Year): 3/20/01

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): 106 milford St. #201 Salisbury MD 21801

State Registrar

31. Dete filed (Month, Day, Year): MAR 21 2001

32. Registrar's Signature: Geneva B Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

June Wilson

LDQ

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 10253

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than 'natural', or Items 23a or 24a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

WJL 6

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Helen Allport Watkins
2. Date of Death: Month March Day 17 Year 2001
3. Time of Death: 11:35am
4a. Facility Name (If not institution, give street and number): 6108 Granby Road
4b. City, Town, or Location of Death: Derwood
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 219-36-1849
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 92 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Dec 2 1908
9. Birthplace (State or Foreign Country): Canada

Usual Residence of Decedent

10a. State: Md
10b. County: Montgomery
10c. City, Town or Location: Gaithersburg
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 25524 Jarl Drive
10f. Zip Code: 20882
10g. Citizen of What Country? USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: white

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 7 College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): clerical
16b. Kind of Business/Industry: health care

17. Father's Name (First, Middle, Last): Willoughby Allport
18. Mother's Name (First, Middle, Maiden Surname): Viola Matthews

19a. Informant's Name/Relationship (Type, Print): J. Eileen Burroughs (daughter)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 25524 Jarl Dr., Gaithersburg, Md. 20882

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Springfield Cemetery
Date: 3-21-01
20c. Location - City or Town, State: Sykesville, Md

21. Signature of Funeral Service Licensee: ▶ Brian L. Haight
22. Name and Address of Facility: Haight Funeral Home & Chapel P.O. Box 195 Sykesville, Md 21784

Medical Certification: To Be Completed by Physician/Medical Examiner

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. myocardial infarction — 5 minutes
Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Alzheimer's Disease - 7 years

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 8☒ Other (Specify) Assisted Living

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Christopher Kearns, M.D.
29c. License number: D39793
29d. Date signed (Month, Day, Year): March 18, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): 12102 Georgia Ave., Wheaton, MD 20902 Christopher J. Kearns, MD

State Registrar

31. Date filed (Month, Day, Year): MAR 2 0 2001
32. Registrar's Signature: ▶ Geneva G Sparks

DHMH 16 Rev 6/95

ORIGINAL

01-1643-045
mnmr
Oris Wooters

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar AMEND ITEM 23a,ptII,27,28a-f per ME G796 061501 SS

Certificate of Death

Reg. No. 2001 10254

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Physician /Medical Examiner

Funeral Director

To Be Completed by Funeral Director

Physician /Medical Examiner

Medical Certification; To Be Completed by Physician/Medical Examiner

State Registrar

1. Decedent's Name (First, Middle, Last)			2. Date of Death Month Day Year	3. Time of Death
ORIS	WILLIAM	WOOTERS	March 24, 2001	4:52 AM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Peninsula Regional Medical Center	Salisbury	Wicomico

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
221-18-1965	1 X M 2 ☐ F	71 Yrs.			September 25,1929	Delaware

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Wicomico	Fruitland	1 X Yes 2 ☐ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
205 Sand Castle Blvd.	21826	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1 ☐ Never Married 2 X Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Merchant Marines	1 ☐ Yes 2 X No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
10	-	Seafood Manager	Giant Food Store

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Meiden Surname)
William Wooters	Lillian Henry

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Betty Wooters/Wife	205 Sand Castle Blvd., Fruitland, MD 21826

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	Salisbury Crematory	3/26/01	Salisbury, MD

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ Keith A Dewey CFSP	Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): CEREBRAL EDEMA AND HYPOXIC-ISCHEMIC ENCEPHALOPATHY COMPLICATING A BRAINSTEM (pontine) HEMORRHAGE AND AN ACUTE LEFT-SIDED SUBDURAL HEMATOMA

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

a. Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown	23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

HYPERTENSIVE ATHEROSCLEROTIC CARDIOVASCULAR DISEASE; ATRIAL FIBRILLATION; FIBRILLATION; DIABETES MELLITUS; CEREBRAL VASCULAR ACCIDENT, REMOTE

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1 X Yes 2 ☐ No	1 X Yes 2 ☐ No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1 X Yes 2 ☐ No	Hospital: 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA	Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1 ☐ Natural 2 X Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined	3-23-01	4:00 & 7:30 AM	1 ☐ Yes 2 X No	subject fell out of hospital bed (twice)

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)
hosptial	Peninsula Regional Medical Center, Wicomico County, MD

29a. Certifier (Check only one): 1 ☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 X **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ Stephen S. Radentz, M.D	O.C.M.E.	March 25, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Stephen S. Radentz 111 Penn Street, Baltimore, Maryland 21201

31. Date filed (Month, Day, Year)	32. Registrar's Signature
MAR 29 2001	▶ Denise G Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 10255

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: CHARLOTTE MATILDA WALLEN

2. Date of Death — Month: MARCH; Day: 18; Year: 2001

3. Time of Death: 9:05 AM

4a. Facility Name *(If not institution, give street and number)*: MEMORIAL HOSPITAL & MEDICAL CENTER

4b. City, Town, or Location of Death: CUMBERLAND

4c. County of Death: ALLEGANY

Funeral Director

5. Social Security Number: 571-09-2716

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 82 Yrs. — If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: SEPT 21 1918

9. Birthplace *(State or Foreign Country)*: CALIF.

Usual Residence of Decedent

10a. State: MARYLAND

10b. County: ALLEGANY

10c. City, Town or Location: CUMBERLAND

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 123 PA. AVENUE

10f. Zip Code: 21502

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No — If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* WHITE

15. Decedent's Education *(Specify only highest grade completed)* — Elementary/Secondary (0-12): 12; College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: CLERK/RETAIL

16b. Kind of Business/Industry: CLERK/RETAIL

17. Father's Name *(First, Middle, Last)*: GEORGE MEADE REIDER

18. Mother's Name *(First, Middle, Maiden Surname)*: NORA CECIL McHENRY

19a. Informant's Name/Relationship *(Type, Print)*: MARJORIE HOWELL DAUGHTER

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 123 PA. AVE CUMBERLAND MARYLAND 21502

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: CUMBERLAND CREMATORY

Date: MARCH 19 2001

20c. Location - City or Town, State: CUMBERLAND MD.

21. Signature of Funeral Service Licensee: Dale L. Merritt

22. Name and Address of Facility: MERRITT-ADAMS FUNERAL HOME P.A. 404 DECATUR STREET CUMBERLAND MARYLAND

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. BACTEREMIA — 1 WEEK

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. CONGESTIVE HEART FAILURE — 3 YEARS

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death *(Check only one)* — Hospital: 1☑ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)* — 1☑ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Terry Williams MD

29c. License number: D16041

29d. Date signed *(Month, Day, Year)*: MARCH 18, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): DR. TERRY WILLIAMS, MEMORIAL HOSPITAL MEDICAL BUILDING, CUMBERLAND, MD 21502

State Registrar

31. Date filed *(Month, Day, Year)*: MAR 20 2001

32. Registrar's Signature: Barbara G Sparks

DHMH 16 Rev 6/95

ORIGINAL

CHARLOTTE WALLEN 571-09-2716

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 28a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

ADMEND ITEM: #5 PER INFORMANT G794 4-10-01 WR

Certificate of Death

Reg. No. 2001 10256

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Donna Alston

2. Date of Death: Month 3 Day 31 Year 01

3. Time of Death: 10 58 AM

4a. Facility Name (If not institution, give street and number): BON SECOURS HOSPITAL

4b. City, Town, or Location of Death: BALTIMORE

4c. County of Death: BALTIMORE

Funeral Director

5. Social Security Number: 212-80-8492 / 212-40-8492

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 42 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): JULY 31, 1958

9. Birthplace (State or Foreign Country): MD

Usual Residence of Decedent

10a. State: MD

10b. County: NA

10c. City, Town or Location: BALTIMORE

10d. Inside City Limits: 1☒ Yes 2☐ No

10a. Street and Number: 6008 CLOVER ROAD

10f. Zip Code: 21215

10g. Citizen of What Country?: USA

11. Meritel Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Wes Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yeer or Detes:

13. Wes Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Bleck, White, etc. Specify: AFRICAN AMERICAN

15. Decedent's Education (Specify only highest grade completed): Elementery/Secondery (0-12): 12; College (1-4or 5+): 4

16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired): COUNSELOR-JUVENILE

16b. Kind of Business/Industry: STATE OF MARYLAND

17. Father's Neme (First, Middle, Last): ROLAND D. CURRY SR.

18. Mother's Neme (First, Middle, Meiden Surname): GERALDINE S. CURRY

19e. Informent's Neme/Reletionship (Type, Print): BRYAN K. ALSTON (HUSBAND)

19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code): 6008 CLOVER ROAD BALTIMORE, MD 21215

20a. Method of Disposition: 1☒ Buriel 2☐ Cremetion 3☐ Removel from Stete 4☐ Donetion 5☐ Other (Specify)

20b. Plece of Disposition (Neme of cemetery, cremetory or other piece): WOODLAWN CEMETERY

Dete: 4/6/2001

20c. Location - City or Town, Stete: BALTIMORE, MARYLAND

21. Signeture of Funerel Service Licensee: [signature]

22. Neme and Address of Fecility: WYLIE FUNERAL HOME PA 638 N. GILMOR STREET BALTIMORE, MD 21217

Physician /Medical Examiner

23a. Pert I. Enter the diseese, or complicetions thet caused the deeth. Do not enter the mode of dying, such es cardiec or respiretory errest, shock, or heert failure. List only one cause on each line.

Approximete Interval Between Onset and Deeth

Immediete Cause (Finel disease or condition resulting in deeth): a. Massive Peritoneal bleeding

Due to (or es a consequence of): b. Severe thrombocytopenia

Sequentially list conditions, if any, leeding to immediete cause. Enter Underlying Cause (Diseese or Injury thet initieted events resulting in deeth) Last

Due to (or es a consequence of): c. Anemia

Due to (or es a consequence of): d. Panereatitis

Part II. **Other significant conditions** contributing to deeth but not resulting in the underlying cause given in Pert I.: Probable cholecystitis. Bipolar Disorder

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was en eutopsy performed? 1☒ Yes 2☐ No

24b. Were eutopsy findings eveilable prior to completion of cause of death? 1☒ Yes 2☐ No

25. Was case referred to medicel exeminer? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospitel: 1☒ Inpetient 2☐ ER/Outpetient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Menner of Death: 1☒ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined

28a. Dete of Injury (Month, Day Yeer)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, dete and place, end due to the cause(s) end manner as stated. 2☐ **Medical Examiner:** On the basis of exeminetion and/or investigetion, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) and menner steted.

29b. Signeture and title of certifier: [signature] MD.

29c. License number: D45925

29d. Date signed (Month, Day, Year): 4-4-01

30. Neme and address of person who completed cause of death (Item 23a) (Type, Print): CHUKWUEMEKA UFOMADU, MD Bon Secours Hospital, Baltimore MD 21223

State Registrar

31. Dete filed (Month, Day, Year): APR 04 2001

32. Registrer's Signeture: [signature]

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

ADH
TREDONNA BROWN
01-1763-510

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar AMEND ITEM 23a,27 per ME G794 042001 SS

Certificate of Death

Reg. No. 2001 10257

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)		2. Date of Death Month / Day / Year	3. Time of Death
Tredonna	Brown	MARCH 30, 2001	1915 P M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
SINAI HOSPITAL	BALTIMORE CITY	NA

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
213-82-0031	1☐M 2☒F	32 Yrs.			08-04-68	MD

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	NA	Baltimore	1☒Yes 2☐No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
10 Liberty Place Apt.#1	21224	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☒Never Married 2☐Married 3☐Widowed 4☐Divorced	1☐Yes 2☒No If Yes, Give Year or Dates:	1☐Yes 2☒No Specify:	Specify: Black

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12th Grade	1yr.	Coordinator	Goodwill Industry

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Bernard Brown	Carol Drummond

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21218
Carol Brown	3900 Yolando Road Baltimore, Maryland

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☐Burial 2☒Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	Metro Crematory	04-06-01	Catonsville,MD

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ Gladys Carnes	Baltimore, Maryland 21202 WM.C.March FH 1101 E. North Avenue

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. SICKLE CELL DISEASE	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of):	
	c. Due to (or as a consequence of):	
	d. Due to (or as a consequence of):	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month / Day / Year
1☐Yes 2☐No 9☐Unknown	1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) _____ 9☐Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?	24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐Yes 2☐No 3☐Probably 4☒Unknown	1☒Yes 2☐No	1☐Yes 2☐No

Medical Certification; To Be Completed by Physician/Medical Examiner

25. Was case referred to medical examiner?	28. Place of Death (Check only one)	
1☒Yes 2☐No	Hospital: 1☐Inpatient 2☐ER/Outpatient 3☒DOA	Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury M	28c. Injury at Work?	28d. Describe how injury occurred
1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined			1☐Yes 2☐No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☒ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ Marjorie McShane MD	OCME	MARCH 31, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Marjorie A. McShane 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
APR 04 2001	▶ Donna G. Sparks

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 10258

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): SAMUEL ERNEST BROWN

2. Date of Death — Month: MARCH Day: 30 Year: 2001

3. Time of Death: 7:25 PM

4a. Facility Name (If not institution, give street and number): Doctors Community Hospital

4b. City, Town, or Location of Death: Lanham

4c. County of Death: Prince Georges

Funeral Director

5. Social Security Number: 314-03-1941

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 87 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Oct 10, 1913

9. Birthplace (State or Foreign Country): Illinois

Usual Residence of Decedent

10a. State: MD

10b. County: Prince Georges

10c. City, Town or Location: Greenbelt

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 12 Green Knoll Place

10f. Zip Code: 20770

10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [ ] Widowed 4 [X] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: WWII

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: white

15. Decedent's Education (Specify only highest grade completed) — Elementary/Secondary (0-12): 12 — College (1-4or 5+): 4

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): professor

16b. Kind of Business/Industry: college

17. Father's Name (First, Middle, Last): Samuel E. Brown

18. Mother's Neme (First, Middle, Maiden Surname): Goldie E. Boots

19a. Informant's Name/Relationship (Type, Print): Ruth Ryan/friend

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): unk

20a. Method of Disposition: 1 [ ] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [X] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee: Ronald S. Wade, Director

22. Name and Address of Facility: State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Acute Myocardial Infarction — 45 minutes

Due to (or as a consequence of):

b. Diabetes Mellitis — 20 years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c. Hypertension — 10 years

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Asthma

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one) — Hospital: 1 [ ] Inpatient 2 [X] ER/Outpatient 3 [ ] DOA — Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Jay Zwally II, M.D.

29c. License number: D0042684

29d. Date signed (Month, Day, Year): March 30, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): JAY H. ZWALLY, MD. 575 MAIN STREET SUITE 253, LAUREL MD 20707

State Registrar

31. Date filed (Month, Day, Year): APR 04 2001

32. Registrar's Signature: Donna G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend Item 26 per Pr. For State Registrar G79404/04/01dhb

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 10259

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)		2. Date of Death Month Day Year	3. Time of Death
John	Boland	March 23, 2001	2:04 P M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
7809 Lockwood Road	Dundalk	Baltimore

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
220-20-2138	XX M 2 F	72 Yrs.			Sept. 22, 1928	Maryland

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Baltimore	Dundalk	1 Yes 2 XX No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
7809 Lockwood Road	21222	United States

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1 Never Married 2 Married XX Widowed 4 Divorced	1 X Yes 2 No If Yes, Give Year or Dates: Korean	1 Yes XX No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12 Years		Inspector	Baltimore Gas Electric Company

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
John C. Boland	Mildred M. Healey

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Mary M. Smolek (Sister)	2825 Lodge Farm Road Apt. 119 Edgemere, MD 21219

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)	Sacred Ht. of Jesus Cem.	3/27/2001	Dundalk, Maryland

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
Gregory E Read	Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Finel disease or condition resulting in death)	a. uncontrolled Diabetis mellitus.	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of): b. Hypertension.	
	Due to (or as a consequence of): c.	
	Due to (or as a consequence of): d.	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month Day Year
1 Yes 2 X No 9 Unknown	1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnent at time of death 5 Other (specify) 9 Unknown	

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Hypertension.

23e. Did tobecco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 X Unknown

24a. Was en autopsy performed? 1 Yes 2 X No

24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No

25. Was case referred to medical examiner? 1 Yes 2 X No

26. Place of Death (Check only one)

Hospital: 1 Inpatient 2 ER/Outpatient 3 X DOA

Other: 4 Nursing Home 5 X Residence 6 Other (Specify)

27. Manner of Death: 1 X Naturel; 2 Accident; 3 Suicide; 4 Homicide; 5 Pending investigation; 6 Could not be determined

28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
	M	1 Yes 2 No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
Rohit Gulati MD	D 51715	3/28/01.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ROHIT GULATI, 2809 BOSTON STREET BALTIMORE MD 21224.

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
APR 04 2001	G Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 10260

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): DOLORES BOWEN
2. Date of Death (Month, Day, Year): March 29 2001
3. Time of Death: 01:20 AM
4a. Facility Name (If not institution, give street and number): The Johns Hopkins Hospital
4b. City, Town, or Location of Death: Baltimore City
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 213 28 1280
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 72 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Feb. 28, 1929
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Anne Arundel
10c. City, Town or Location: Glen Burnie
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 1015 Upton Road
10f. Zip Code: 21060
10g. Citizen of What Country?: U.S.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12th | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Clerk
16b. Kind of Business/Industry: Social Security

17. Father's Name (First, Middle, Last): Raymond Watt
18. Mother's Name (First, Middle, Maiden Surname): Gertrude Kron

19a. Informant's Name/Relationship (Type, Print): Dwight Bowen / Son
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 406 Brooks Court Glen Burnie, Maryland 21060

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Bayview Crematory, Inc.
Date: 3/30/01
20c. Location - City or Town, State: Baltimore, Maryland

21. Signature of Funeral Service Licensee: Sharron Leggett
22. Name and Address of Facility: Gonce Funeral Home P.A. 4001 Ritchie Highway Baltimore, Md. 21225

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. METASTATIC BLADDER CANCER	9 MONTHS
Due to (or as a consequence of):		
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	b. RENAL FAILURE	1 WEEK
Due to (or as a consequence of):		
	c.	
Due to (or as a consequence of):		
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☑ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☑ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No
26. Place of Death (Check only one): Hospital: 1☑ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 8☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: PHYSICIAN
29c. License number: 26-200
29d. Date signed (Month, Day, Year): MARCH 29, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): MOHAN R. RENGEN 600 N. WOLFE STREET BALTIMORE, MD 21287

State Registrar

31. Date filed (Month, Day, Year): APR 04 2001
32. Registrar's Signature: Geneva G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black indelible ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 10261

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month / Day / Year	3. Time of Death
JOHN BUCHAL	APRIL 3, 2001	7:29 AM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
HARBOR HOSPITAL CENTER	BALTIMORE	N/A

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
212 40 4620	1☒M 2☐F	60 Yrs.			March 31, 1941	Maryland

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Anne Arundel	Baltimore	1☐Yes 2☒No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
831 Matthews Avenue	21225	U.S.

11. Marital Status	12. Was Decedent Ever In U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐Never Married 2☒Married 3☐Widowed 4☐Divorced	1☐Yes 2☒No If Yes, Give Year or Dates:	1☐Yes 2☒No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12th		Deli	Giant

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Charles Buchal	Adele Williams

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Arlene Buchal / Wife	831 Matthews Avenue Baltimore, Maryland 21225

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☐Burial 2☒Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	Bayview Crematory, Inc.	4/6/01	Baltimore, Maryland

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
Sharron Liggett	Gonce Funeral Home P.A. 4001 Ritchie Highway Baltimore, Md. 21225

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. LUNG CANCER	1996 to Present
	Due to (or as a consequence of):	
Sequentially list conditions, If any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	b.	
	Due to (or as a consequence of):	
	c.	
	Due to (or as a consequence of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☑Yes 2☐No 3☐Probably 4☐Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐Yes 2☑No	1☐Yes 2☑No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐Yes 2☑No	Hospital: 1☑Inpatient 2☐ER/Outpatient 3☐DOA	Other: 4☐Nursing Home 5☐Residence 8☐Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☑Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined		M	1☐Yes 2☐No	
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)

29e. Certifier (Check only one) 1☑**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner es stated. 2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
Gustavo F. Ros M.D.	P14433	April 3, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
GUSTAVO F. ROS HARBOR HOSPITAL BALTIMORE, MARYLAND.

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
APR 04 2001	Geneva G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 10262

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): MARSHALL LEE BLUM JR.
2. Date of Death (Month, Day, Year): April 2, 2001
3. Time of Death: 16:58
4a. Facility Name (If not institution, give street and number): 4216 Sheldon Ave.
4b. City, Town, or Location of Death: Baltimore City
4c. County of Death: n/a

Funeral Director

5. Social Security Number: 216-36-5657
8. Sex: 1 ☒ M 2 ☐ F
7. Age (In yrs. last birthday): 63 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 11/15/1937
9. Birthplace (State or Foreign Country): MD

Usual Residence of Decedent

10a. State: MD
10b. County: n/a
10c. City, Town or Location: Baltimore City
10d. Inside City Limits: 1 ☒ Yes 2 ☐ No
10e. Street and Number: 4216 Sheldon Ave.
10f. Zip Code: 21206
10g. Citizen of What Country?: United States

11. Marital Status: 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☒ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☒ Yes 2 ☐ No If Yes, Give Year or Dates: Peacetime
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Dispatcher
16b. Kind of Business/Industry: Umerley Trucking Co.

17. Father's Name (First, Middle, Last): Marshall Lee Blum, Sr.
18. Mother's Name (First, Middle, Maiden Surname): Mary Mannel

19a. Informant's Name/Relationship (Type, Print): Shawn Blum /son
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 63 Valley Street Glen Rock, PA 17327

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Oaklawn Cemtery | Date: 04/07/01
20c. Location - City or Town, State: Baltimore, MD

21. Signature of Funeral Service Licensee: Stephen D. Coster M01122
22. Name and Address of Facility: Ruck Towson Funeral Home. Inc. 1050 York Road Towson, Maryland 21204

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiec or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Finel disease or condition resulting in death) a.	angina	2 months
Due to (or as a consequence of): b.	diabetes	sev. years
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury thet initieted events resulting in death) Last — Due to (or as a consequenca of): c.	chronic UTI	sev.years
d.		

Part II. **Other significant conditione** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☑ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☑ No

25. Was case referred to medical examiner? 1 ☑ Yes 2 ☐ No
26. Place of Death (Check only one): Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | Other: 4 ☐ Nursing Home 5 ☑ Residence 6 ☐ Other (Specify)
27. Manner of Death: 1 ☑ Naturel 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how Injury occurred
28e. Piece of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street end Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1 ☑ **Certifying Physician:** To the best of my knowledge, deeth occurred et the tima, date end place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or Investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and manner stated.

29b. Signeture and title of certifier: [signature] M.D.
29c. License number: D0046649
29d. Date signed (Month, Day, Year): 04/03/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): ESMERALDA M. del ROSARIO, M.D.

State Registrar

31. Date filed (Month, Day, Year): APR 04 2001
32. Registrar's Signeture: [signature] G Sparks

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

6 of 1

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 10263

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death (Month, Day, Year)	3. Time of Death
Charles Oliver Briggs	March 28 2001	455 PM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Union Memorial Hospital	Baltimore	N/A

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
219 18 9694	1 [X] M 2 [ ] F	75 Yrs.			June 30, 1925	Maryland

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Anne Arundel	Pasadena	1 [ ] Yes 2 [X] No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
7973 Central Road	21122	U.S.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced	1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: WW II	1 [ ] Yes 2 [X] No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
	1 year	Superintendent	Construction

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Oliver Briggs	Emma E. White

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Rosemarie Billings Briggs	7973 Central Road Pasadena, Maryland 21122

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	MD State Veteran Cem.	4/2/01	Crownsville, Maryland

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
Donna M Zaranowski	Gonce Funeral Home P.A. 4001 Ritchie Highway Baltimore, Md. 21225

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Sepsis	3 weeks
	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Pneumonia	4 weeks
	Due to (or as a consequence of):	
	c. Lung Cancer	1 year
	Due to (or as a consequence of):	
	d. Cor Pulmunale	1 year

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery
1 [ ] Yes 2 [ ] No 9 [ ] Unknown	1 [ ] Live birth 2 [ ] Fetal death 3 [ ] Ectopic pregnancy 4 [ ] Pregnant at time of death 5 [ ] Other (specify) _____ 9 [ ] Unknown	Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Coronary Artery Disease

Deep Venous Thrombosis

23e. Did tobacco use contribute to the cause of death?	24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown	1 [ ] Yes 2 [X] No	1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1 [ ] Yes 2 [X] No	Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA	Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined		M	1 [ ] Yes 2 [ ] No	
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one)

1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
Stacy D. Garrett, M.D.	AT2438946	March 28, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

STACY D. GARRETT, M.D., 201 East University Pkwy, Baltimore, MD 21218

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
APR 04 2001	Geneva G Sparks

To be Completed by Funeral Director

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

To be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 10264

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: CLARK N. CLUGSTON
2. Date of Death (Month, Day, Year): APRIL 2, 2001
3. Time of Death: 8:55 A.M.
4a. Facility Name *(If not institution, give street and number)*: GOOD SAMARITAN NURSING HOME
4b. City, Town, or Location of Death: BALTIMORE
4c. County of Death:

Funeral Director

5. Social Security Number: 154-03-6261
6. Sex: 1 [X] M 2 [ ] F
7. Age *(In yrs. last birthday)*: 82 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
6. Date of Birth *(Month, Day, Year)*: JAN. 22, 1919
9. Birthplace *(State or Foreign Country)*: NEW JERSEY

Usual Residence of Decedent

10a. State: MARYLAND
10b. County: BALTIMORE
10c. City, Town or Location: PERRY HALL
10d. inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 63 PERRYFALLS PLACE
10f. Zip Code: 21236
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [ ] Nevar Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Giva Yeer or Detes: W.W.II
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No *Specify:*
14. Rece - American Indien, Black, White, etc. *Specify:* WHITE

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 YRS. / Collega (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: SELF EMPLOYED-OWNER
16b. Kind of Business/Industry: HOME IMPROVEMENT

17. Father's Name *(First, Middle, Last)*: EDGAR CLUGSTON
18. Mother's Neme *(First, Middle, Maiden Sumama)*: GRACE AMMERMAN

19a. Informant's Name/Ralationship *(Type, Print)*: GLORIA F. CLUGSTON
19b. Mailing Address *(Street end Number or Rural Routa Number, City or Town, Steta, Zip Coda)*: 63 PERRYFALLS PLACE PERRYHALL, MARYLAND 21236

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*
20b. Piece of Disposition *(Name of cemetery, crematory or other piece)*: GARRISON FOREST
Dete: APRIL 5, 2001
20c. Location - City or Town, State: GARRISON, MARYLAND
21. Signature of Funeral Service Licensee ▶
22. Name and Address of Facility: EVANS CHAPEL OF MEMORIES 8300 HARFORD ROAD PARKVILLE MARYLAND 21234

Physician /Medical Examiner

23a. Pert1. Entar tha diseasa, or complications that ceused tha daath. Do not enter tha mode of dying, such as cardiac or respiratory arrast, shock, or heart failure. List only one cause on each line.
Approximate Interval Between Onsat and Death

Immediate Cause (Finat disaase or condition resulting in death)
a. CARCINOMA LUNG METASTASIC — Due to (or as e consequence of):
Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Diseese or injury that initieted events resulting in daath) Last
b. Dua to (or es a consequence of):
c. Due to (or as e consequence of):
d.

IF FEMALE:
23b. Was decedent pregnent in the past 12 months? 1 [ ] Yes 2 [X] No 9 [ ] Unknown
23c. If yes, outcome of pregnancy 1 [ ] Live birth 2 [ ] Fatel deeth 3 [ ] Ectopic pregnancy 4 [ ] Pregnant at tima of daath 5 [ ] Other *(specify)* 9 [ ] Unknown
23d. Dete of delivery: Month / Day / Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: CHRONIC OBSTRUCTIVE LUNG DISEASE

23e. Did tobecco use contribute to the cause of death? 1 [ ] Yas 2 [ ] No 3 [X] Probably 4 [ ] Unknown
24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were eutopsy findings availabla prior to compiation of cause of death? 1 [ ] Yes 2 [ ] No

25. Wes case referred to medical examiner? 1 [ ] Yes 2 [X] No
26. Place of Deeth *(Check only ona)*: Hospitel: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Othar: 4 [X] Nursing Home 5 [ ] Residence 6 [ ] Other *(Specify)*
27. Manner of Death: 1 [X] Natural 2 [ ] Accidant 3 [ ] Suicida 4 [ ] Homicida 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury *(Month, Day Yaar)*
28b. Time of Injury
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Dascribe how injury occurred
26a. Place of Injury - At homa, farm, street, factory, office building, etc. *(Specify)*
26f. Location *(Street end Number or Rural Route Number, City or Town, Stete)*

29a. Certifier *(Check only one)*: 1 [X] **Certifying Physician:** To the best of my knowledga, daath occurred et the tima, date and place, and due to the cause(s) and manner es steted. 2 [ ] **Medical Examiner:** On tha basis of axemination and/or investigation, in my opinion, daath occurred et the time, data and place, and dua to the cause(s) end manner stated.
29b. Signature and title of certifier ▶
29c. License number: D20390
29d. Date signed *(Month, Day, Yeer)*: APRIL 3, 2001
30. Name and address of person who completed cause of daath (Item 23a) (Type, Print): DR. CHARLES HOESCH, M.D. 9718 BLAIR ROAD PERRY HALL, MD 21236

State Registrar

31. Dete filed *(Month, Day, Yeer)*: APR 04 2001
32. Registrar's Signeture ▶ Geneva G Sparks

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23e or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Medical Certification; To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 10265

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: GENISE CARNEY
2. Date of Death Month / Day / Year: APRIL 02, 2001
3. Time of Death: 14:48
4a. Facility Name *(If not institution, give street and number)*: JOHNS HOPKINS HOSPITAL
4b. City, Town, or Location of Death: BALTIMORE City
4c. County of Death:

Funeral Director

5. Social Security Number: 219-58-5979
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 47 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: MAY 4, 1953
9. Birthplace *(State or Foreign Country)*: MD

Usual Residence of Decedent

10a. State: MD
10b. County: NA
10c. City, Town or Location: BALTIMORE
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 903 N. STREEPER STREET
10f. Zip Code: 21205
10g. Citizen of What Country?: USA

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yaar or Datas:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yas, specity Cuben, Mexican, Puarto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indien, Black, White, etc. *Specify:* AFRICAN AMERICAN

15. Decedent's Education *(Specify only highest grade completed)*: Elementery/Secondery (0-12): 12th; College (1-4or 5+): NA
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: CHILDCARE
16b. Kind of Business/Industry: SITTER

17. Father's Name *(First, Middle, Last)*: SAMUEL CARNEY
18. Mother's Neme *(First, Middle, Meiden Surneme)*: LILLIE M. CARNEY

19a. Informent's Neme/Reletionship *(Type, Print)*: CAROLYN C. SMITH (SISTER)
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, Stete, Zip Code)*: 2607 E. MADISON STREET BALTIMORE, MD 21205

20e. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donetion 5☐ Other *(Specify)*
20b. Piece of Disposition *(Neme of cemetery, cremetory or other piece)*: VOSHELL MEMORIAL GARDENS
Date: 4/4/01
20c. Location - City or Town, State: DUNDALK MARYLAND

21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: WYLIE FUNERAL HOME PA 638 N. GILMOR STREET BALTIMORE, MD 21217

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not entar tha moda of dying, such as cardiac or respiretory arrest, shock, or heart failura. List only one ceuse on eech line.

Approximate Interval Between Onset and Death

Immediete Ceuse (Final disaasa or condition resulting in death)
a. HEPATITIS C — 20 YEARS
Due to (or es a consequence of):
b.
Due to (or as a consequence of):
Sequentielly list conditions, if any, leeding to immediete cause. Enter Underlying Cause (Diseese or Injury that initieted events resulting in deeth) Last
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contributa to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Was en autopsy performed? 1☐ Yes 2☑ No

24b. Were eutopsy findings available prior to completion of cause of death? 1☐ Yes 2☑ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death *(Check only one)*: Hospitel: 1☑ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 8☐ Other *(Specify)*

27. Menner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined

28a. Dete of Injury *(Month, Dey Year)*
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Pleca of Injury - At home, farm, street, fectory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☑ **Certifying Physician:** To the best of my knowledge, deeth occurred at the time, date end place, and due to the cause(s) and menner as stated. 2☐ **Medical Examiner:** On tha basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature] MD
29c. Licanse number: RES-000
29d. Dete signed *(Month, Dey, Year)*: APRIL 02, 2001

30. Neme and address of person who completed cause of death (Item 23a) (Type, Print): DAVID A. ZIDAR JOHNS HOPKINS HOSPITAL; BALTIMORE, MD 21287

State Registrar

31. Date filed *(Month, Day, Year)*: APR 04 2001
32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 10266

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: JAMES CROCKETT, JR.

2. Date of Death Month / Day / Year: APRIL 01, 2001

3. Time of Death: 9:50AM

4a. Facility Name *(If not institution, give street and number)*: HOWARD COUNTY GENERAL

4b. City, Town, or Location of Death: COLUMBIA

4c. County of Death: BALTIMORE/HOWARD

Funeral Director

5. Social Security Number: 212-42-6670

6. Sex: X 1 M 2 F

7. Age *(In yrs. last birthday)*: 69 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: DEC. 07, 1931

9. Birthplace *(State or Foreign Country)*: MARYLAND

Usual Residence of Decedent

10a. State: MD

10b. County:

10c. City, Town or Location: COLUMBIA

10d. Inside City Limits: 1 Yes 2 X No

10e. Street and Number: 5009 DURHAM ROAD WEST

10f. Zip Code: 21044

10g. Citizen of What Country?: U.S.A.

11. Marital Status: X 1 Never Married 2 Married 3 Widowed 4 Divorced

12. Wes Decedent Ever in U.S. Armed Forces? 1 Yes 2 X No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 X No Specify:

14. Race - American Indian, Black, White, etc. Specify: BLACK

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): NONE / College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: BUS BOY

16b. Kind of Business/Industry: FAST FOOD/RESTAURANT

17. Father's Name *(First, Middle, Last)*: JAMES CROCKETT, SR

18. Mother's Name *(First, Middle, Maiden Surname)*: ESSIE MILLER

19a. Informent's Neme/Relationship *(Type, Print)*: ETHEL CRICKETT/SISTER

19b. Mailing Address *(Street end Number or Rural Route Number, City or Town, State, Zip Code)*: 4406 LOCH RAVEN BLVD · BALTO. MD 21218

20a. Method of Disposition: X 1 Burial 2 Cremation 3 Removal from Stete 4 Donation 5 Other *(Specify)*

20b. Piece of Disposition *(Neme of cemetery, cremetory or other piece)*: KING PARK CEMETERY

Date: 4/6/01

20c. Location - City or Town, State: BALTO. MD

21. Signature of Funeral Service Licensee: [signature] MO1015

22. Neme end Address of Facility: VAUGHN C. GREENE FUNERAL SERVS 4905 YORK ROAD BALTIMORE, MARYLAND 21212

Physician /Medical Examiner

23a. Part1. Enter the disease, or complicetions thet caused the deeth. Do not enter the mode of dying, such es cardiac or respiretory arrest, shock, or heert failure. List only one ceuse on each line.

Approximate Interval Between Onset and Death

Immedlete Cause (Finel diseese or condition resulting in death)

a. Acute MYOCARDIAL INFARCT — Instant

Due to (or as a consequence of):

b. Hypertension — Cyclic

Sequentially list conditions, if any, leading to immediete cause. Enter Underlying Cause (Diseese or Injury thet initiated events resulting in death) Last

Due to (or es a consequence of):

c.

Due to (or es a consequence of):

d.

Pert II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Part I.

cerebrovascular accident

Mental Retardation

23b. Did tobacco use contribute to the cause of death? 1 Yes 2 X No 3 Probably 4 Unknown

24a. Wes en autopsy performed? 1 Yes 2 X No

24b. Were autopsy findings available prior to completion of ceuse of death? 1 Yes 2 No

25. Was cese referred to medicel examiner? 1 Yes 2 X No

26. Place of Death *(Check only one)*: Hospital: 1 Inpatient 2 ER/Outpetient 3 DOA — Other: 4 Nursing Home 5 Residence 6 X Other *(Specify)* ASSISTED LIVING

27. Manner of Death: X 1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined

28a. Dete of Injury *(Month, Dey Year)*

28b. Time of Injury M

28c. Injury et Work? 1 Yes 2 No

28d. Describe how injury occurred

28e. Piece of Injury - At home, ferm, street, fectory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, Stete)*

29e. Certifier *(Check only one)*: X 1 **Certifying Physician**: To the best of my knowledge, deeth occurred et the time, dete and piece, end due to the cause(s) and manner as stated. 2 **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature end title of certifier: [signature] MD

29c. License number: D 12039

29d. Dete signed *(Month, Dey, Year)*: APR 3, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): WALTER R WELZANT MD 7600 OSLER DR TOWSON, MD 21204

State Registrar

31. Date filed *(Month, Day, Year)*: APR 04 2001

32. Registrar's Signature: [signature]

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit copy.

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 10267

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): THOMAS COLES SR.
2. Date of Death: Month APRIL Day 01 Year 2001
3. Time of Death: 11:04A
4a. Facility Name (If not institution, give street and number): Bon Secours Hospital
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 215-64-7529
6. Sex: 1☒M 2☐F
7. Age (In yrs. last birthday): 45 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Aug. 24, 1955
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: N/A
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1☒Yes 2☐No
10e. Street and Number: 1912 Braddish Ave.
10f. Zip Code: 21216
10g. Citizen of What Country?: USA

11. Marital Status: 1☒Never Married 2☐Married 3☐Widowed 4☐Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐Yes 2☒No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No Specify:
14. Race - American Indian, Black, White, etc. Specify: African American

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 10 | College (1-4or 5+): 0
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Attendant
16b. Kind of Business/Industry: Lexington Market Parking Lot

17. Father's Name (First, Middle, Last): Horace Coles
18. Mother's Name (First, Middle, Maiden Surname): Doris Jacobs

19a. Informant's Name/Relationship (Type, Print): Mr. & Mrs. Horace Coles (parents)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2842 W. Lanvale St. Balto. Md. 21216

20a. Method of Disposition: 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Mt. Zion
Date: 4/5/2001
20c. Location - City or Town, State: Lansdowne, Md.

21. Signature of Funeral Service Licensee: ▶ Joseph L. Russ
22. Name and Address of Facility: Joseph L. Russ Funeral Home 2222 W. North Ave. Balto. Md. 21216

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) a.	HEPATIC ENCEPHALOPATHY	3 DAYS
Due to (or as a consequence of): b.	LIVER FAILURE with JAUNDICE	UNKNOWN
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last — Due to (or as a consequence of): c.	HEPATITIS	4
Due to (or as a consequence of): d.	INTRA-VENOUS DRUG USE	2

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

- PANCYTOPENIA with COAGULOPATHY
- RENAL FAILURE

23b. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☒Unknown

24a. Was an autopsy performed? 1☐Yes 2☒No
24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☐No

25. Was case referred to medical examiner? 1☐Yes 2☒No

26. Place of Death (Check only one): Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death: 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐Yes 2☐No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ M.D
29c. License number: D 23300
29d. Date signed (Month, Day, Year): APRIL 01 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): SUDHIR PATEL — BON SECOURS HOSP. BALTIMORE MD. 21223

State Registrar

31. Date filed (Month, Day, Year): APR 04 2001
32. Registrar's Signature: ▶ Bernice G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 10268

215-64-3494

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month / Day / Year	3. Time of Death
Gregory, M. Courville	March 27 01	4:43PM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Baltimore VA medical center	Baltimore	N/A

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Yaar: Months / Deys	If Under 24 Hrs.: Hours / Min.	8. Data of Birth (Month, Day, Yaar)	9. Birthplaca (State or Foraign Country)
215-64-3494	1☐M 2☐F	46 Yrs.			02-18-1955	MD.

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Insida City Limits
MD	Annearundel	Pasadena	1☐Yes 2☑No

10e. Street and Number	10f. Zip Coda	10g. Citizen of What Country?
3909 Alberta Ave	21122	USA

11. Maritel Status	12. Was Decedent Evar in U.S. Armed Farces?	13. Was Decedent of Hispanic Origin? (Specify Yas or No- If Yas, specify Cuban, Maxican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐Never Married 2☐Married 3☐Widowed 4☑Divorced	1☐Yes 2☐No If Yas, Giva Yaar or Datas:	1☐Yes 2☑No Specify:	Specify: White

15. Decedent's Education (Specify only highast grada completad)		16a. Decedent's Usual Occupation (Give kind of work dona during most of working lifa. DO NOT use retired)	16b. Kind of Buainass/Industry
Elamentary/Secondary (0-12)	College (1-4or 5+)		
12th	2 yrs	Self Employed	water Filtration

17. Fathar's Nama (First, Middla, Last)	18. Mothar's Nama (First, Middla, Maiden Surnama)
Francis E. Courville Jr.	Theda Mary

19a. Informant's Name/Ralationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code)
Theda Courville-Henn/Mother	3909 Alberta Ave

20a. Mathod of Disposition	20b. Placa of Disposition (Nama of cemetery, cramatory or othar placa)	Data	20c. Location - City or Town, Stata
1☐Burial 2☑Cremation 3☐Ramoval from State 4☐Donation 5☐Othar (Specify)	Metro Crematory	3/3/01	Balto. MD.

21. Signatura of Funaral Service Licensaa	22. Nama and Addrass of Facility
▶ Vaughn C Dunn	Cremation Services 5151 Balto. Nat'l Pike Balto. MD 21229

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part1. Enter tha disaasa, or complications that caused the death. Do not enter the mode of dying, auch as cardiac or respiretory arrest, shock, or haart failura. List only ona cause on aach line.

		Approximate Interval Between Onset and Death
Immediata Cause (Final disaasa or condition resulting in death)	a. Sepsis	7 days
Due to (or as a consequanca of):	Cirrhosis	14
Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disaasa or Injury that initiated evants resulting in death) Last	b. Due to (or as a consequance of):	
	c. Due to (or as a consequence of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying causa given in Part I.

23b. **Did tobacco use contribute to the cause of death?** 1☐Yes 2☑No 3☐Probably 4☐Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of causa of death?
1☑Yes 2☐No	1☐Yas 2☑No

25. Was case referred to medical examiner?	28. Place of Death (Check only ona)	
1☑Yas 2☐No	Hospital: 1☑Inpatient 2☐ER/Outpatient 3☐DOA	Other: 4☐Nursing Homa 5☐Rasidence 6☐Othar (Specify)

27. Mannar of Death	28a. Date of Injury (Month, Day Year)	28b. Tima of Injury	28c. Injury at Work?	28d. Dascribe how injury occurred
1☑Natural 2☐Accident 3☐Suicide 4☐Homicida 5☐Panding Invaatigation 6☐Could not be datarmined		M	1☐Yas 2☐No	
	28a. Placa of Injury - At homa, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Routa Number, City or Town, Stata)

29a. Certifiar (Check only one) 1☐ **Certifying Physician:** To tha best of my knowledga, daath occurred at tha tima, data and placa, and due to tha cause(s) and mannar as statad.
2☐ **Medical Examiner:** On tha basis of examinetion and/or invastigation, in my opinion, daath occurred at the tima, data and placa, and due to the cause(s) and mannar stated.

29b. Signatura and title of certifiar	29c. License number	29d. Data signed (Month, Day, Year)
▶ Jorge Uribe MD	P14654	3/27/01

30. Nama and addrass of parson who completed causa of death (Item 23a) (Type, Print) Jorge Uribe MD BVAMC 101 N. Greene St Baltimore MD 21201

State Registrar

31. Data filed (Month, Day, Year)	32. Registrar's Signatura
APR 04 2001	▶ Bernie G Sparks

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic avant, the Medical Examiner must be notified at once.**

To the Hospital or Attending Physician: The law requiras that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 10269

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)		2. Date of Death Month Day Year	3. Time of Death
John	Dragula	March 31, 2001	10:22am

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Harbor Hospital Center	Baltimore	NA

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
224-53-9703	1☐M 2☐F XX	78 Yrs.			05-14-22	PA

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	NA	Baltimore	1☒Yes 2☐No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
611 S. Charles Street	21230	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐Never Married 2☐Married 3☐Widowed XX 4☐Divorced	1☐Yes 2☐No XX If Yes, Give Year or Dates:	1☐Yes 2☐No XX Specify:	Specify: Black

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
None	NA	Never-work	Never-work

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Meiden Sumame)
Frank Dragula	Anna Tovtin

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21231
Mary Pallag	603 S. Ann Street Apt.#208 Baltimore, MD.

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	St. Andrew Orthodox Cem.	04-05-01	Dundalk, MD

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ Gladys Wanner	Baltimore, Maryland 21202 WM.C.March FH 1101 E. North Avenue

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. SEPTIC SHOCK	UNKNOWN
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of): b. ASPIRATION PNEUMONIA	
	Due to (or as a consequence of): c. ILEUS	
	Due to (or as a consequence of): d.	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month Day Year
1☐Yes 2☐No 9☐Unknown	1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?	24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐Yes 2☐No 3☐Probably 4☒Unknown	1☐Yes 2☒No	1☐Yes 2☒No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐Yes 2☒No	Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA	Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined		M	1☐Yes 2☐No	
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification; To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one)
1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) end manner as steted.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ MD	RES 000	MARCH 31, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
TSHERING AMDO, HARBOR HOSPITAL CENTER, BALTIMORE, MD 21225

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
APR 04 2001	▶ Geneva G Sparks

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 10270

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): LAURA B DYSON
2. Date of Death: Month APRIL Day 2 Year 2001
3. Time of Death: 645A
4a. Facility Name (If not institution, give street and number): STELLA MARIS HOSPICE
4b. City, Town, or Location of Death: BALTIMORE
4c. County of Death:

Funeral Director

5. Social Security Number: 228.38.4344
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 67 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): JAN. 12, 1934
9. Birthplace (State or Foreign Country): VIRGINIA

Usual Residence of Decedent

10a. State: MD
10b. County:
10c. City, Town or Location: CATONSVILLE
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 947 SOUTHRIDGE ROAD
10f. Zip Code: 21228
10g. Citizen of What Country?: U.S.A.
11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: BLACK
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): | College (1-4or 5+): 2YRS
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use ratired): CLERK
16b. Kind of Business/Industry: GOVERNMENT
17. Father's Name (First, Middle, Last): LEWIS PURDIE
18. Mother's Name (First, Middle, Maidan Sumama): PINKEY ELLIS
19a. Informant's Neme/Relationship (Type, Print): PAUL DYSON/HUSBAND
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Coda): 947 SOUTHRIDGE ROAD · CATONSVILLE, MD 21228
20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other piece): KING PARK CEMETERY | Date: 4/7/01
20c. Location - City or Town, State: BALTIMORE, MD
21. Signature of Funeral Service Licensee: [signature] M01015
22. Name and Address of Facility: VAUGHN C. GREENE FUNERAL SERVICE 4905 YORK ROAD BALTIMORE, MARYLAND 21212

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Metastatic Breast Cancer

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☐ Residence 6☒ Other (Specify) STELLA MARIS AT MERCY HOSPICE

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature] MD
29c. License number: D40854
29d. Date signed (Month, Day, Year): April 2, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): DAVID RISEBERG 301 St Paul Pl BALTIMORE MD 21202

State Registrar

31. Date filed (Month, Day, Year): APR 04 2001
32. Registrar's Signature: [signature] G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 10271

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): MARY CELESTE BEIL DIETER

2. Date of Death (Month, Day, Year): March 30, 2001

3. Time of Death: 8:10 pm

4a. Facility Name (If not institution, give street and number): Greater Baltimore Medical Center

4b. City, Town, or Location of Death: Towson

4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 217-48-4766

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 85 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Sept. 21, 1915

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Baltimore

10c. City, Town or Location: Timonium

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 2300 Dulaney Valley Road

10f. Zip Code: 21093

10g. Citizen of What Country? U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 10 years

College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker

16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): John George Beil

18. Mother's Name (First, Middle, Maiden Surname): Johanna Bechman

19a. Informant's Name/Relationship (Type, Print): J. James Dieter (son)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 608 Windwood Road Baltimore, Maryland 21212

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Most Holy Redeemer Cemetery

Date: 4-3-01

20c. Location - City or Town, State: Baltimore, Maryland

21. Signature of Funeral Service Licensee: George J. Ferraro

22. Name and Address of Facility: Mitchell-Wiedefeld Funeral Home, Inc. 6500 York Road Baltimore, Maryland 21212

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death):

a. Generalized metastasis — years

Due to (or as a consequence of): Bowel / Future — days

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and Title of certifier: Eddie Nakhuda MD

29c. License number: D 15504

29d. Date signed (Month, Day, Year): 2nd April 01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Eddie Nakhuda, M.D. 2300 Dulaney Valley Rd Timonium, Md 21093

State Registrar

31. Date filed (Month, Day, Year): APR 04 2001

32. Registrar's Signature: B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 28a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

NAME: DIETER, MARY

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 | 0272

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Margarete Eichhorn

2. Date of Death: Month April, Day 2, Year 2001

3. Time of Death: 10:55 pm

4a. Facility Name (If not institution, give street and number): 5234 Mozart Terrace

4b. City, Town, or Location of Death: Lothian

4c. County of Death: Anne Arundel

Funeral Director

5. Social Security Number: None

6. Sex: 1☐ M XX F

7. Age (In yrs. last birthday): 92 Yrs.

If Under 1 Yaar: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Aug. 5, 1908

9. Birthplace (State or Foreign Country): Switzerland

Usual Residence of Decedent

10a. State: MD

10b. County: Anne Arundel

10c. City, Town or Location: Lothian

10d. Insida City Limits: 1☐ Yas 2☐ No XX

10e. Street and Number: 5234 Mozart Terrace

10f. Zip Code: 20711

10g. Citizen of What Country?: Germany

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Wes Decedent Ever in U.S. Armed Forcas? 1☐ Yas XX No If Yas, Give Yaar or Datas:

13. Was Decedent of Hispanic Origin? (Specify Yas or No- If Yas, specify Cuban, Maxicen, Puarto Rican, atc.) 1☐ Yas 2☒ No Specify:

14. Race - American Indien, Bleck, White, atc. Specify: White

15. Decedent's Education (Specify only highast grada completed): Elementary/Secondary (0-12): 12; College (1-4or 5+):

16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired): Homemaker

16b. Kind of Business/Industry: Own Home

17. Father's Nema (First, Middle, Last): Albert Kilchling

18. Mothar's Name (First, Middle, Maiden Sumama): Pauline Uebele

19a. Informant's Name/Ralationship (Type, Print): Doris Schmitz - Daughter

19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, State, Zip Code): 5234 Mozart Terrace, Lothian, MD 20711

20a. Mathod of Disposition: 1☐ Buriel 2☒ Cremation 3☐ Removal from Stata 4☐ Donation 5☐ Othar (Specify)

20b. Place of Disposition (Nama of cemetery, cramatory or othar place): Metro Crematory

Date: 4/4/01

20c. Location - City or Town, Stata: Baltimore, MD

21. Signature of Funaral Sarvice Licansae: [signature]

22. Nama and Address of Facility: Hardesty Funeral Home, P.A. 12 Ridgely Avenue, Annapolis, MD 21401

Physician /Medical Examiner

23a. Part1. Enter the disease, or complicetions thet caused the death. Do not antar tha mode of dying, such as cerdiac or raspiratory arrest, shock, or haart failure. List only one causa on aach lina.

Approximate Intervat Between Onsat and Death

Immediate Cause (Final disease or condition resulting in death) a. CHF — 4 Yrs

Dua to (or as a consaquance of):

Sequentially list conditions, if any, leading to immediate causa. Entar Underlying Cause (Disease or injury that initieted evants resulting in death) Last

b.

Dua to (or as a consaquance of):

c.

Due to (or es e consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in tha underlying ceusa givan in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yas 2☒ No

24b. Wara autopsy findings available prior to completion of cause of death? 1☐ Yas 2☐ No

25. Was casa rafarred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatiant 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Homa 5☐ Residence 6☒ Othar (Specify) Daughters Residence

27. Mannar of Death: 1☐ Natural 2☐ Accidant 3☐ Suicida 4☐ Homicida 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At homa, farm, straat, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Routa Number, City or Town, Stata)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To tha best of my knowladga, death occurred at the time, date and place, and dua to the cause(s) and mannar as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at tha time, data and piece, and dua to the cause(s) and mannar stated.

29b. Signature and title of certifier: [signature] MD

29c. License number: 030718

29d. Data signed (Month, Day, Year): 4-3-2001

30. Nama and address of person who completed ceusa of death (Item 23a) (Type, Print): John Jackson MD, 2003 Medical Pkwy, #100, Annapolis, MD 21401

State Registrar

31. Date filed (Month, Day, Year): APR 0 4 2001

32. Registrar's Signatura: [signature] G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 28a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 10273

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Jacqueline Taylor Frazier

2. Date of Death: Month March 29, Day, 2001 Year

3. Time of Death: 12:25 a M

4a. Facility Name *(If not institution, give street and number)*: Genesis Eldercare

4b. City, Town, or Location of Death: Randallstown

4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 218-36-9706

6. Sex: 1☐M 2☒F

7. Age *(In yrs. last birthday)*: 64 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Mar 13, 1937

9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decadent

10a. State: MD.

10b. County: N/A

10c. City, Town or Location: Baltimore

10d. Insida City Limits: 1☒Yes 2☐No

10e. Street end Number: 5118 Gwynn Oak Avenue

10f. Zip Code: 21207

10g. Citizan of Whet Country?: USA

11. Marital Status: 1☐Nevar Married 2☐Married 3☒Widowed 4☐Divorced

12. Was Decedent Ever in U.S. Armed Forcas? 1☐Yes 2☒No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No Specify:

14. Rece - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education *(Spacify only highest grada completed)*: Elemantary/Secondary (0-12): 12th; Collega (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Seamtress

18b. Kind of Business/Industry: Tailoring

17. Father's Name *(First, Middle, Last)*: James Taylor

18. Mother's Name *(First, Middle, Maiden Surname)*: Wilhelmina Smith

19a. Informant's Name/Reletionship *(Type, Print)*: Gwendolyn Taylor (Sister)

19b. Mailing Address *(Straat and Number or Rural Route Number, City or Town, Stata, Zip Coda)*: 5118 Gwynn Oak Avenue Baltimore, Maryland 21207

20a. Method of Disposition: 1☒Buriel 2☐Cramation 3☐Ramovel from State 4☐Donation 5☐Othar *(Specify)*

20b. Placa of Disposition *(Name of cametery, crematory or other place)*: Garrison Forest Vet

Date: 04/05/01

20c. Location - City or Town, Stete: Owings Mills, MD.

21. Signature of Funeral Service Licensee: Dennis B Caple

22. Name and Address of Facility: Dennis B. Caple Funeral Home, P.A. 4601 York Road Baltimore, Maryland 21212

Physician /Medical Examiner

23a. Part1. Enter tha disease, or complications that caused tha daath. Do not enter the mode of dying, such as cardiac or raspiratory arrast, shock, or heart failure. List only one cause on eech line.

Immediata Cause (Final disaase or condition resulting in deeth)

a. OBSTRUCTIVE NEPHROPATHY / Due to (or as a consequenca of):

b. PELVIC MASS / Due to (or as a consequenca of):

Sequantially list conditions, if eny, leeding to immediete causa. Enter Underlying Ceuse (Disaese or injury that initieted events resulting in death) Last

c. Due to (or as a consequance of):

d.

Approximata Interval Betwaen Onset end Death: a. MONTHS; b. MONTHS

IF FEMALE:

23b. Was decedent pregnant in tha past 12 months? 1☐Yes 2☑No 9☐Unknown

23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fatel deeth 3☐Ectopic pregnancy 4☐Pregnent at time of deeth 5☐Other *(specify)* 9☐Unknown

23d. Date of delivery Month Dey Year

Part II. **Other significant conditions** contributing to deeth but not resulting in the underlying causa given in Part I.

DIABETES, RHEUMATIC HEART DISEASE, ATRIAL FIBRILLATION, ASCVD

23e. Did tobecco use contribute to tha cause of death? 1☐Yes 2☐No 3☐Probably 4☐Unknown

24a. Was an autopsy performed? 1☐Yes 2☐No

24b. Were autopsy findings available prior to completion of cause of death? 1☐Yas 2☐No

25. Wes casa referred to medical axeminer? 1☐Yes 2☐No

26. Place of Death *(Check only one)*: Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☐Residenca 8☐Other *(Specify)*

27. Manner of Death: 1☐Natural 2☐Accident 3☐Suicida 4☐Homicida 5☐Panding investigetion 6☐Could not be datermined

28a. Date of Injury *(Month, Day Yaer)*

28b. Time of Injury

28c. Injury at Work? 1☐Yes 2☐No

28d. Describe how injury occurred

28a. Placa of Injury - At homa, farm, street, factory, offica building, atc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☐**Certifying Physician:** To the bast of my knowladga, daeth occurrad at tha tima, date and placa, and dua to tha cause(s) and manner es stated. 2☐**Medical Examiner:** On tha basis of examination and/or investigation, in my opinion, death occurred at tha tima, data end place, end due to the causa(s) end manner stated.

29b. Signature and title of certifier: K.M. [illegible] MD

29c. License number: D20333

29d. Deta signed *(Month, Day, Yaer)*: APRIL 4, 2001

30. Neme and address of person who complated cause of death (Item 23a) (Type, Print): K. JONES MD 1838 GREENTREE RD PIKESVILLE MD

State Registrar

31. Data filed *(Month, Dey, Yaer)*: APR 04 2001

32. Registrar's Signature: [signature]

DHMH 17 Rev 1/2001

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 10274

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death (Month, Day, Year)	3. Time of Death
DAVID ALVIN FRANKLIN-HARRIS	March 28, 2001	4:15 AM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
SOUTHERN MARYLAND HOSPITAL CENTER	Clinton	Prince Georges

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months	If Under 1 Year: Days	If Under 24 Hrs.: Hours	If Under 24 Hrs.: Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
none	1☒ M 2☐ F	Yrs.			5	59	Mar 27, 2001	Maryland

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	Prince Georges	Clinton	1☐ Yes 2☒ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
11646 Cosca Park Drive	20735	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced	1☐ Yes 2☒ No If Yes, Give Year or Dates:	1☐ Yes 2☒ No Specify:	Specify: black

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
none	none	none	none

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Demetrius Harris	Rachel O. Franklin

19a. Interment's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Southern Md Hospital	7502 Surratts Rd Clinton, MD 20735

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☐ Burial 2☐ Cremation 3☐ Removal from State 4☒ Donation 5☐ Other (Specify)			

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
Ronald S. Wade, Director	State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	e. IMMATURITY	6 hours
	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b.	
	Due to (or as a consequence of):	
	c.	
	Due to (or as a consequence of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. **Did tobacco use contribute to the cause of death?** 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐ Yes 2☑ No	1☐ Yes 2☐ No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐ Yes 2☑ No	Hospital: 1☑ Inpatient 2☐ ER/Outpatient 3☐ DOA	Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined		M	1☐ Yes 2☐ No	
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
Ernesto R. Gallardo M.D.	D42190	3/28/2001

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)
ERNESTO DANIEL GALLARDO SOUTHERN MD HOSP CTR

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
APR 04 2001	Geneva G Sparks

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

)!_!&01-1758-510
crn
Stella Friar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 10275

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)			2. Data of Death Month	Day	Year	3. Time of Death
Stella	Dorothy	Friar	March	30	2001	5:40 P M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Johns Hopkins Bayview Medical Center	Baltimore	N/A

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Data of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
216-32-8879	1☐M 2☒F	64 Yrs.			July 31 1936	Maryland

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Baltimore	Dundalk	1☐Yes 2☒No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
7 Kinship Rd.	21222	U.S. of America

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐Never Married 2☐Married 3☒Widowed 4☐Divorced	1☐Yes 2☒No If Yes, Give Year or Dates:	1☐Yes 2☒No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	18b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
8	NA	Seamstress	Tailor Shop

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Joseph Ferenc	Gertrude McKenna

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Bill Neumann (SON)	311 McSherrywoods Dr. Littlestown, Pa. 17340

20a. Method of Disposition	20b. Place of Disposition (Name of cemetary, crematory or other place)	Date	20c. Location - City or Town, State
1☐Burial 2☒Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	Metro	April 3,2001	Baltimore, Maryland

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ Mark A. Chojnacki	W. Dabrowski-Chojnacki F.H.'s P.A. 1005 Dundalk Ave. Balto.,Md. 21224

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	Arteriosclerotic Cardiovascular Disease	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to (or as a consequence of):	
	b. Due to (or as a consequence of):	
	c. Due to (or as a consequence of):	
	d.	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month Day Year
1☐Yes 2☒No 9☐Unknown	1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) _____ 9☐Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

CREST Syndrome

23a. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☒Probably 4☐Unknown

Inspection

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐Yes 2☒No	1☐Yes 2☐No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☒Yes 2☐No	Hospital: 1☐Inpatient 2☒ER/Outpatient 3☐DOA	Other: 4☐Nursing Home 5☐Residence 8☐Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined		M	1☐Yes 2☐No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one)

1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2☒ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ J. Locke M.D.	O.C.M.E.	April 02, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

J. Laron Locke M.D. 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
APR 04 2001	▶ Geneva G. Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No: 2001 10276

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): George Gaines

2. Date of Death (Month, Day, Year): MARCH 30 2001

3. Time of Death: 6:00 PM

4a. Facility Name (If not institution, give street and number): St. Agnes Hospital

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: NA

Funeral Director

5. Social Security Number: 214-62-5382

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 48 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): 10-07-52

9. Birthplace (State or Foreign Country): MD

Usual Residence of Decedent

10a. State: MD

10b. County: NA

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1 [X] Yes 2 [ ] No

10e. Street and Number: 452 Random Road

10f. Zip Code: 21229

10g. Citizen of What Country? USA

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: Causion

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 8th Grade

College (1-4or 5+): NA

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Floor Technician

16b. Kind of Business/Industry: Charlestown Co.

17. Father's Name (First, Middle, Last): Unknown

18. Mother's Name (First, Middle, Maiden Surname): Unknown

19a. Informant's Name/Relationship (Type, Print): Charlene Gaines

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 452 Random Road Baltimore, Maryland 21229

20a. Method of Disposition: X [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): King Mem. Pk. Cem.

Date: 04-05-01

20c. Location - City or Town, State: Randallstown, MD

21. Signature of Funeral Service Licensee: ▶ Gladys Wamsley

22. Name and Address of Facility: Baltimore, Maryland 21202 WM.C. March FH 1101 E. North Avenue

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. CARDIAC ARREST — HOURS

Due to (or as a consequence of):

b. SEPSIS — DAYS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c. PNEUMONIA, LEFT LOWER LOBE LUNG — 10 DAYS

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

WEIGHT LOSS

CHANGE IN MENTAL STATUS

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [✓] Unknown

24a. Was an autopsy performed? 1 [✓] Yes 2 [ ] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [✓] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [✓] No

26. Place of Death (Check only one)

Hospital: 1 [✓] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA

Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [✓] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [✓] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Bridget C. Kahntroff MD

29c. License number: D20788

29d. Date signed (Month, Day, Year): APRIL 2, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): BRIDGET C. KAHNTROFF MD 900 LATON AVE., BALTIMORE, MD 21229

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

GEORGE THOMAS GAINES, JR.

Division of Vital Records, P.O. Box 68760,

State Registrar

31. Date filed (Month, Day, Year): APR 04 2001

32. Registrar's Signature: Gerdine G Sparks

DHMH 16 Rev 6/95

ORIGINAL

RJD
ELAUNA GRIFFIN
01-1772-510

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar AMEND ITEM 23a,27 per ME G794 042401 SS

Certificate of Death

Reg. No. 2001 10277

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)			2. Date of Death Month Day Year	3. Time of Death
Elauna	Nicole	Griffin	MARCH 31, 2001	1902 P.M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
UNION MEMORIAL HOSPITAL	BALTIMORE	

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
219-17-7091	1☐M 2☒F	28 Yrs.			03 20 73	M.D.

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	Baltimore	Pikesville	1☐Yes 2☒No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
8102 Tapscott Ct.	21208	U.S.A.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☒Never Married 2☐Married 3☐Widowed 4☐Divorced	1☐Yes 2☒No If Yes, Give Year or Dates:	1☐Yes 2☒No Specify:	Specify: Black

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12th grade	4yrs	Actress	The Everyman Theatre Company

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Alonzo Griffin	Dale V. Parker

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Alonzo Griffin-Father	8102 Tapscott Ct. Pikesville Md 21208

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	Druid Ridge Ceme.	4/6/01	Pikesville, Md

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ Elayna B. Kole	March F/H West 4300 Wabash Ave, Baltimore, Md 21215

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. ASTHMA	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of): b.	
	Due to (or as a consequence of): c.	
	Due to (or as a consequence of): d.	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month Day Year
1☐Yes 2☒No 9☐Unknown	1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?	24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐Yes 2☐No 3☐Probably 4☒Unknown	1☒Yes 2☐No	1☒Yes 2☐No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☒Yes 2☐No	Hospital: 1☐Inpatient 2☒ER/Outpatient 3☐DOA	Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

Medical Certification; To Be Completed by Physician/Medical Examiner

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined		M	1☐Yes 2☐No	
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☒ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ J. M. Titus	O.C.M.E.	MARCH 31, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
JACK M. TITUS M.D. 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
APR 04 2001	▶

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 10278

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Esther Graham
2. Date of Death Month Day Year: 03-27-2001
3. Time of Death: 7:35pm
4a. Facility Name *(If not Institution, give street and number)*: Stella Maris
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 218-40-4908
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 60 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: 03-25-1941
9. Birthplace *(State or Foreign Country)*: MD.

Usual Residence of Decedent

10a. State: MD
10b. County: N/A
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 1027 Cathedral St.
10f. Zip Code: 21201
10g. Citizen of What Country?: USA

11. Meritel Status: 1☐ Never Married 2☐ Merried 3☐ Widowed 4☒ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* Black

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondery (0-12): 12th | College (1-4or 5+): N/A
16a. Decedent's Usual Occupetion *(Give kind of work done during most of working life. DO NOT use retired)*: Sales
16b. Kind of Business/Industry: Retail

17. Father's Name *(First, Middle, Last)*: James Mallory
18. Mother's Name *(First, Middle, Maiden Surname)*: Phillis Madden

19a. Informant's Name/Relationship *(Type, Print)*: Patricia Bishop / Sister
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 300 E. Pennsylvania Ave. Towson MD. 21286

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removel from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Neme of cemetery, crematory or other place)*: Metro Crematory
Date: 3/30/01
20c. Location - City or Town, State: Balto. MD.

21. Signeture of Funeral Service Licensee: Vaughn C Dunn
22. Name and Address of Facility: Cremation Services P.A. 5151 Balto. Nat'l Pike Balto. MD. 21229

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that ceused the deeth. Do not enter the mode of dying, such as cerdiac or respiratory errest, shock, or heart failure. List only one cause on each line.

Approximate Intervel Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. LUNG CANCER
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b.
Due to (or as e consequence of):
c.
Due to (or es e consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Part I.

23b. **Did tobacco use contributa to the cause of death?** 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☐ Residence 6☒ Other *(Specify)* HOSPICE

27. Menner of Death: 1☒ Netural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined
28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, dete end place, end due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examinetion end/or investigetion, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier
29c. License number: D43725
29d. Dete signed *(Month, Day, Year)*: 3/28/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): DR. TARIQ MAHMOOD 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093

State Registrar

31. Date filed *(Month, Day, Year)*: APR 04 2001
32. Registrar's Signature: Barbara G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attanding Physician: The law requires thet the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

MARCH 27, 2001 7:35 p.m.

ESTHER GRAHAM

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 10279

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Mary Joel Gunzelman
2. Date of Death Month Day Year: March 31, 2001
3. Time of Death: 10:30 P M

4a. Facility Name (If not institution, give street and number): Maria Health Care Center
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 219-18-3174
6. Sex: 1☐M 2☒F
7. Age (In yrs. last birthday): 76 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Oct. 3, 1924
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: MD
10b. County: Baltimore
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1☐Yes 2☒No
10e. Street and Number: 6401 N. Charles Street
10f. Zip Code: 21212
10g. Citizen of What Country? USA

11. Marital Status: 1☒Never Married 2☐Married 3☐Widowed 4☐Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐Yes 2☒No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4or 5+): 4
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Teacher
16b. Kind of Business/Industry: Parochial school

17. Father's Name (First, Middle, Last): Joseph Gunzelman
18. Mother's Name (First, Middle, Maiden Surname): Marie Ulbrich

19a. Informant's Name/Relationship (Type, Print): Bernice Feilinger, SSND
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 6401 N. Charles St., Baltimore, MD 21212

20a. Method of Disposition: 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Villa Maria Cemetery
Date: 4/3/2001
20c. Location - City or Town, State: Glen Arm, MD

21. Signature of Funeral Service Licensee: Robert M. Kretz
22. Name and Address of Facility: Mitchell-Wiedefeld Funeral Home, 6501 York Road, Baltimore, MD 21212

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiec or respiratory arrest, shock, or heart failure. List only one ceuse on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death):
a. Cerebral-Vascular Accident — 10 Days

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
Due to (or as a consequence of):
b. Diabetes Mellitus
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐Yes 2☒No 9☐Unknown
23c. If yes, outcome of pregnancy: 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown
23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

24a. Was an autopsy performed? 1☐Yes 2☒No
24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☐No

25. Was case referred to medical examiner? 1☐Yes 2☒No

28. Place of Death (Check only one): Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA; Other: 4☒Nursing Home 5☐Residence 8☐Other (Specify)

27. Manner of Death: 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐Yes 2☐No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification; To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☒Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Neal M. Friedlander MD
29c. License number: D28673 Maryld
29d. Date signed (Month, Day, Year): 4/2/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Neal Friedlander, MD; 6565 N. Charles St.; Towson, MD 21204

State Registrar

31. Date filed (Month, Day, Year): APR 04 2001
32. Registrar's Signature: Geneva G Sparks

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23e or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

2

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 10280

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: THOMAS HAYES
2. Date of Death Month: APRIL Day: 02 Year: 2001
3. Time of Death: 20:37 HRS
4a. Facility Name *(If not institution, give street and number)*: GOOD SAMARITAN HOSPITAL
4b. City, Town, or Location of Death: BALTIMORE
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 168-26-1181
6. Sex: 1 ☒ M 2 ☐ F
7. Age *(In yrs. last birthday)*: 68 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: 8/2/1932
9. Birthplace *(State or Foreign Country)*: PENNSYLVANIA

Usual Residence of Decedent

10a. State: MD
10b. County: BALTIMORE
10c. City, Town or Location: PARKVILLE
10d. Inside City Limits: 1 ☐ Yes 2 ☒ No
10e. Street and Number: 1823 EDGEWOOD ROAD
10f. Zip Code: 21234
10g. Citizen of What Country?: USA

11. Meritel Stetus: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced
12. Wes Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Yeer or Dates:
13. Wes Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☐ No Specify:
14. Rece - American Indian, Bleck, White, etc. Specify: WHITE

15. Decedent's Education *(Specify only highest grede completed)*: Elementery/Secondary (0-12): 12TH GRADE; College (1-4or 5+):
16a. Decedent's Usuel Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: MANUFACTURE'S REP.
16b. Kind of Business/Industry: PLUMBING SUPPLIES

17. Fether's Neme *(First, Middle, Last)*: THOMAS J. HAYES, SR.
18. Mother's Neme *(First, Middle, Maiden Surneme)*: CATHERINE CAMPBELL

19a. Informant's Neme/Reletionship *(Type, Print)*: CATHERINE M. HAYES WIFE
19b. Meiling Address *(Street and Number or Rural Route Number, City or Town, Stete, Zip Code)*: 1823 EDGEWOOD ROAD BALTIMORE, MD 21234

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremetion 3 ☐ Removel from Stete 4 ☐ Donetion 5 ☐ Other *(Specify)*
20b. Piece of Disposition *(Name of cemetery, cremetory or other pleca)*: DULANEY VALLEY MEM. GAR.
Dete: 4/6/01
20c. Location - City or Town, Stete: COCKEYSVILLE, MD

21. Signeture of Funerel Service Licensee: [signature]
22. Neme end Address of Fecility: THE JOHNSON FUNERAL HOME, P.A. 8521 LOCH RAVEN BLVD. TOWSON, MD 21286

Physician /Medical Examiner

23a. Part I. Enter the diseese, or complicetions thet caused the deeth. Do not enter the mode of dying, such es cardiec or respiratory errest, shock, or heert feilure. List only one ceuse on eech line.

Approximete Interval Between Onset and Deeth

Immediete Cause (Finel diseese or condition resulting in deeth): a. ACUTE EXACERBATION OF CHRONIC CONGESTIVE HEART FAILURE

Due to (or es e consequence of):

Sequentielly list conditions, if any, leeding to immediete cause. Enter Underlying Cause (Diseese or injury thet initieted eventa resulting in deeth) Last:

b. SEPSIS

Due to (or as a consequence of):

c. LEFT LOWER EXTREMITY CELLULITIS

Due to (or es e consequenca of):

d. SEVERE PERIPHERAL VASCULAR DISEASE

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

ACUTE RENAL FAILURE

CORONARY ARTERY DISEASE

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Wes en eutopsy performed? 1 ☐ Yes 2 ☒ No

24b. Were eutopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No

26. Place of Death *(Check only one)*: Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other *(Specify)*

27. Menner of Death: 1 ☒ Neturel 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigetion 6 ☐ Could not be determined

28a. Dete of Injury *(Month, Dey Year)*
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Plece of Injury - At home, ferm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street end Number or Rural Route Number, City or Town, Stete)*

29a. Certifier *(Check only one)*: 1 ☒ **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, date and place, end due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of exeminetion and/or investigetion, in my opinion, deeth occurred et the time, date end placa, and due to the cause(s) and menner steted.

29b. Signeture and title of certifier: [signature], RESIDENT PHYSICIAN
29c. License number: P13450
29d. Date signed *(Month, Day, Year)*: APRIL 02, 2001

30. Neme and address of person who completed cause of death (Item 23a) (Type, Print): KOFI A. APPIAH, MD; GOOD SAMARITAN HOSPITAL, BALTIMORE

State Registrar

31. Date filed *(Month, Day, Year)*: APR 04 2001
32. Registrer's Signeture: [signature]

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 10281

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Scott Allen Hudson
2. Deta of Death: Month April Day 03, Year 2001
3. Time of Death: 12:05 A.M.
4a. Facility Neme (If not institution, give street and number): Gilchrist Center
4b. City, Town, or Location of Death: Towson
4c. County of Death: Baltimore Co.

Funeral Director

5. Social Security Number: 215-08-8945
6. Sex: 1☒ M 2☐ F
7. Age (In yrs. last birthday): 31 Yrs. | If Under 1 Yeer: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Dete of Birth (Month, Day, Year): May 21, 1969
9. Birthplace (Stete or Foraign Country): Harrisburg,PA.

Usuel Residence of Decedent

10a. Steta: Maryland
10b. County: N/A
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 6300 The Alameda
10f. Zip Code: 21239
10g. Citizen of Whet Country?: United States of America

11. Meritel Stetus: 1☒ Nevar Married 2☐ Married 3☐ Widowed 4☐ Divorced
12. Wes Decedent Ever in U.S. Armed Forces? 1☐ Yas 2☒ No If Yes, Give Yaar or Detes:
13. Wes Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, atc.): 1☐ Yes 2☒ No Specify:
14. Race - American Indien, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementery/Secondery (0-12): 12 | College (1-4or 5+): 02
16a. Decedent's Usuai Occupation (Giva kind of work done during most of working life. DO NOT use retired): Restaurant Manager
16b. Kind of Business/Industry: The Cheesecake Factory

17. Fethar's Neme (First, Middle, Last): Michael Joseph Kurilec
18. Mother's Neme (First, Middle, Maiden Surneme): Linda Rose Frankhouser

19a. Informent's Name/Reletionship (Type, Print): Miss Holly D. Burkett(Fiancee')
19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 6300 The Alameda Baltimore, Maryland 21239

20a. Mathod of Disposition: 1☒ Buriel 2☐ Cremetion 3☐ Removal from Stete 4☐ Donetion 5☐ Other (Specify)
20b. Piece of Disposition (Name of cemetary, crematory or other place): Dulaney Valley Mem.Gardens
Dete: 4/05/2001
20c. Location - City or Town, Stata: Timonium, Maryland

21. Signeture of Funerel Service Licensee: Jeffrey L. Gair, Sr. ▶ Jeffrey L. Gair, Sr.
22. Name end Address of Facility: Ruck Towson Funeral Home, inc. 1050 York Rd. Towson, Md. 21204

Physician /Medical Examiner

23a. Part I. Enter tha diseesa, or complications that caused tha daath. Do not entar tha moda of dying, such as cardiac or raspiretory errest, shock, or heart feilure. List only one ceuse on eech line.

Approximate Interval Between Onset end Deeth

Immediete Ceuse (Finel diseese or condition resulting in death)
a. renal cell carcinoma — 3 years
Due to (or as e consequence of):
Sequentially list conditions, if eny, leeding to immadiete cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b.
Due to (or es e consequence of):
c.
Due to (or es e consequence of):
d.

Part II. **Other significant conditions** contributing to deeth but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Wes en autopsy performed? 1☐ Yas 2☒ No
24b. Were autopsy findings available prior to completion of cause of deeth? 1☐ Yes 2☐ No

25. Wes case referred to medical examiner? 1☐ Yes 2☒ No
26. Piece of Deeth (Check only one): Hospitel: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☒ Other (Specify) Hospice
27. Menner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined
28a. Dete of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, date end place, end due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examinetion and/or investigetion, in my opinion, deeth occurred et the time, date and place, end due to the cause(s) and menner steted.
29b. Signetura and title of certifier: ▶ A Anthony Riley, MD
29c. License number: D25205
29d. Date signed (Month, Day, Year): April 3, 2001
30. Name and address of person who completed cause of deeth (Item 29a) (Type, Print): W. A. Riley 6300 N. Charles St. Balto, MD

State Registrar

31. Date filed (Month, Day, Year): APR 04 2001
32. Registrar's Signatura: Geneva G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 28a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

12:05 am
Hudson, Scott April 3, 2001
12

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 10282

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Mary A. Houston
2. Data of Death — Month: MARCH Day: 31, Year: 2001
3. Time of Death: 10 15 pm
4a. Facility Name (If not institution, give street and number): Stella Maris at Mercy
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 220-36-8560
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 60 Yrs.
If Under 1 Yaar — Months: Days:
If Under 24 Hrs. — Hours: Min.:
8. Date of Birth (Month, Day, Year): May 14, 1940
9. Birthplace (State or Foreign Country): Virginia

Usual Residence of Decedent

10a. State: Maryland
10b. County: N/A
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 905 N. Luzerne Ave.
10f. Zip Code: 21205
10g. Citizen of What Country? USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forcas? 1☐ Yes 2☒ No If Yas, Give Yaar or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puarto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed) — Elementary/Secondery (0-12): 10 — College (1-4or 5+): 0
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): HouseKeeping
16b. Kind of Business/Industry: Hospital

17. Father's Name (First, Middle, Last): Charlie Lawson
18. Mother's Name (First, Middle, Maiden Surname): Alberta Brandon

19a. Informant's Name/Relationship (Type, Print): (Son) Mr. Tony Houston Jr.
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2031 E. Biddle St. Balto. Md. 21213

20a. Mathod of Disposition: 1☐ Burial 2☒ Cramation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, cremetory or other piece): Greenmount Crematory
Date: 4/6/2001
20c. Location - City or Town, State: Balto. Md.

21. Signature of Funeral Service Licensee: Joseph L. Russ
22. Name and Address of Facility: Joseph L. Russ Funeral Home 2222 W. North Ave. Balto. Md. 21216

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrast, shock, or heart failure. List only ona cause on aach line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Metastatic Head and Neck Cancer

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
b.
Due to (or as a consequenca of):
c.
Dua to (or as a consequence of):
d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco uaa contribute to the cause of death? 1☐ Yea 2☐ No 3☐ Probably 4☐ ~~Unknown~~

24a. Wes en autopsy performed? 1☐ Yes 2☑ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case refarred to medical examiner? 1☐ Yes 2☑ No
26. Piece of Death (Check only one) STELLA MARIS AT MERCY
Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA
Other: 4☐ Nursing Home 5☐ Residenca 6☐ ~~Other~~ (Specify) HOSPICE

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigetion 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, offica building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29e. Certifier (Check only one)
1☐ ~~Certifying Physician~~: To the best of my knowledge, death occurred at the time, date and placa, and due to the cause(s) and manner as stated.
2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, dete end place, end due to the cause(s) and manner stated.

29b. Signature and title of Certifier:
29c. License number: D40854
29d. Date signed (Month, Day, Year): April 2, 2001

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): DAVID RISEBERG 301 St Paul Pl Baltimore, MD 21202

State Registrar

31. Date filed (Month, Day, Year): APR 04 2001
32. Registrar's Signature:

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 10283

3/31/01 3:53 am Halloran, John

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

Funeral Director

To Be Completed by Funeral Director

1. Decedent's Name (First, Middle, Last): JOHN FREDERICK HALLORAN		2. Date of Death (Month, Day, Year): March 31, 2001	3. Time of Death: 3:53AM
4a. Facility Name (If not institution, give street and number): Gilchrist Center	4b. City, Town, or Location of Death: Towson	4c. County of Death: Baltimore	
5. Social Security Number: 213-36-8163	6. Sex: XX 1☐M 2☐F	7. Age (In yrs. last birthday): 60 Yrs.	If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): July 27, 1940	9. Birthplace (State or Foreign Country): Illinois		

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Baltimore	Lutherville	1☐Yes 2☐No XX

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
125 Warwick Drive	21093	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
XX 1☐Never Married 2☐Married 3☐Widowed 4☐Divorced	1☐Yes XX 2☐No If Yes, Give Year or Dates:	1☐Yes XX 2☐No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
	4	Researcher	Military Publishing

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
John Francis Halloran	Loretta Dalton

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Eleanor H. Senft Sister	2617 Marrow Drive Newport News Virginia 23606

20a. Method of Disposition	20b. Place of Disposition (Name of cemetary, crematory or other place)	Date	20c. Location - City or Town, State
1☐Burial XX Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	Greenmount Cemetery	4/3/01	Baltimore, Maryland

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ Dennis Stephen Menake	Mitchell-Wiedefeld Funeral Home Inc. 6500 York Road Baltimore, Maryland 21212

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Lung cancer	4 months
	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b.	
	Due to (or as a consequence of):	
	c.	
	Due to (or as a consequence of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☒Yes 2☐No 3☐Probably 4☐Unknown

24a. Was an autopsy performed? 1☐Yes 2☒No

24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☐No

25. Was case referred to medical examiner? 1☐Yes 2☒No

26. Place of Death (Check only one): Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA; Other: 4☐Nursing Home 5☐Residence 6☒Other (Specify) Hospice

27. Manner of Death: 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury M

28c. Injury at Work? 1☐Yes 2☐No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ [signature]	D25205	March 31, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): W. A. Raley GBMG 6201 N. Charles St. Balto. Md 21204

31. Date filed (Month, Day, Year)	32. Registrar's Signature
APR 04 2001	▶ [signature] P. Sparks

State Registrar

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 10284

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)			2. Date of Death Month	Day	Year	3. Time of Death
Josephine	HARRIET	JACKSON	April	2	2001	0040 M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Union Mem. Hosp.	BALTO.	N/A.

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year Months	Days	If Under 24 Hrs. Hours	Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
219-28-1789	1☐M 2☒F	77 Yrs.					NOV. 6, 1923	MD.

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD.	N/A.	BALTO.	1☒Yes 2☐No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
2226 Fireton Rd	21220	U.S.A

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Rece - American Indian, Black, White, etc.
1☐Never Married 2☐Married 3☒Widowed 4☐Divorced	1☐Yes 2☒No If Yes, Give Year or Dates:	1☐Yes 2☒No Specify:	Specify: Black.

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementery/Secondery (0-12)	College (1-4or 5+)		
11grade	No	Housewife	Keeper of the Home

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Meiden Surname)
William Wall	Hattie Bry

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Mary Bell	2220 Fireton Rd. Balto. MD. 21220

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	Balto. Nat. Cem.	4-5-01	Balto. MD.

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
Patricia Betts	Betts Funeral Home 1629 N. Caroline St. Balto. MD. 21213

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such es cardiec or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Finel disease or condition resulting in death)	a. Abdominal Wound sepsis	1 week
Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of): b.	
	Due to (or es a consequence of): c.	
	Due to (or as a consequence of): d.	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month Day Year
1☐Yes 2☒No 9☐Unknown	1☐Live birth 2☐Fetal death 3☐Ectopic pregnency 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Sacral Decubitus

23e. Did tobacco use contribute to the cause of death?	24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐Yes 2☐No 3☐Probably 4☒Unknown	1☐Yes 2☒No	1☐Yes 2☒No

25. Wes case referred to medical examiner?	28. Place of Death (Check only one)	
1☐Yes 2☒No	Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA	Other: 4☐Nursing Home 5☐Residence 8☐Other (Specify)

27. Menner of Death	28a. Dete of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work?	28d. Describe how injury occurred
1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigetion 6☐Could not be determined			1☐Yes 2☐No	
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification; To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one) 1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as steted. 2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date end place, and due to tha cause(s) end manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
D Watson, M.D.	AT 2438946	April 2, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Deborah Watson, M.D. Union Memorial Hospital 201 East University Parkway, Baltimore, MD 21218

State Registrar

31. Dete filed (Month, Dey, Year)	32. Registrar's Signature
APR 04 2001	Beverly D Sparks

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use es the burial-transit

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 10285

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Willie JOHNSON
2. Date of Death: Month MARCH Day 28 Year 2001
3. Time of Death: 11:45 AM

4a. Facility Name (If not institution, give street and number): BonSecours Health System
4b. City, Town, or Location of Death: BALTIMORE
4c. County of Death:

Funeral Director

5. Social Security Number: 215 12 4220
8. Sex: 1 ☑ M 2 ☐ F
7. Age (In yrs. last birthday): 84 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): FEBRUARY 14, 1917
9. Birthplace (State or Foreign Country): VIRGINIA

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: MARYLAND
10b. County:
10c. City, Town or Location: BALTIMORE
10d. Inside City Limits: 1 ☑ Yes 2 ☐ No
10e. Street and Number: 1710 GWYNN FALLS PARKWAY
10f. Zip Code: 21217
10g. Citizen of What Country? USA

11. Marital Status: 1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☑ No Specify:
14. Race - American Indian, Black, White, etc. Specify: BLACK

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 8 / College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): CRANE OPERATOR
16b. Kind of Business/Industry: STEEL

17. Father's Name (First, Middle, Last): THOMAS JOHNSON
18. Mother's Name (First, Middle, Maiden Surname): MARY BELT

19a. Informant's Name/Relationship (Type, Print): SALLIE M. JOHNSON/WIFE
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1710 GWYNN FALLS PARKWAY BALTIMORE, MD 21217

20a. Method of Disposition: 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): GARRISON FOREST CEMETERY
Date: 4/3/01
20c. Location - City or Town, State: OWINGS MILLS, MD.

21. Signature of Funeral Service Licensee: Kathleen Whitfield Jordan MA01015
22. Name and Address of Facility: VAUGHN C. GREENE FUNERAL SERVICE 4905 YORK ROAD BALTIMORE, MD. 21212

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death):
a. ADULT Respiratory Failure — 03/02/01

Due to (or as a consequence of):
b. CARCINOMA of Sigmoid colon — Unknown

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

03/02/01. Subtotal Colectomy. Wedge resection of liver lesion

03/15/01. Revising ileostomy for fecal stenosis leakage

3/23/01. DRAINAGE of Intraabdominal Abscess and cholecystectomy

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one): Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1 ☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Kwang N. Kim MD
29c. License number: D 17031
29d. Date signed (Month, Day, Year): March 28, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): KWANG N. KIM MD. 2000 W. BALTIMORE ST. BALTIMORE MD 21223

State Registrar

31. Date filed (Month, Day, Year): APR 04 2001
32. Registrar's Signature: Geneva G Sparks

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

1- For State Registrar

Reg. No. 2001 10286

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
Falpher Jones	Apr 1, 2001	7:25 p.m. M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Oasys Eldercare, Inc.	Columbia	Howard

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
185-01-7457	1☐M 2☐F	85 Yrs.			Oct 12, 1915	Virginia

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Howard	Columbia	1☐Yes 2☐No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
9506 Half Dollar Ct.	21046	U.S.A.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐Never Married 2☐Married 3☐Widowed 4☐Divorced	1☐Yes 2☐No If Yes, Give Year or Dates:	1☐Yes 2☐No Specify:	Specify: Black

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12		Postal Worker	U.S. Post Office

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Willis Jones	Mary Corprew

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Ms. Andrea Jones	9506 Half Dollar Ct. Columbia, Maryland 21046

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☐Burial 2☒Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	All County Cremation Services, Inc.	04/07/01	Sykesville, Maryland

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ [signature] 10113	Slack Funeral Home, P.A. 3871 Old Columbia Pike Ellicott City, MD 21043

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Sepsis	days
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of): b. Prostate Cancer	months
	Due to (or as a consequence of): c.	
	Due to (or as a consequence of): d.	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1☐Yes 2☐No 9☐Unknown	23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown	23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?	24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐Yes 2☒No 3☐Probably 4☐Unknown	1☐Yes 2☒No	1☐Yes 2☐No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐Yes 2☒No	Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA	Other: 4☐Nursing Home 5☐Residence 6☒Other (Specify) Assisted Living

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work?	28d. Describe how injury occurred
1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined			1☐Yes 2☐No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one)
1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ [signature] MD	D36786	April 3, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
7061 Deepage Drive, Suite 104, Columbia Maryland 21045, Jeffrey Katz M.D.

5

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
APR 04 2001	▶ Geneva G Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

Amend Item 26 per DRG79404/04/01dhb

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 | 0287

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Marian J. Jackson
2. Date of Death (Month, Day, Year): March 28, 2001
3. Time of Death: 12:30 P.M.
4a. Facility Name (If not institution, give street and number): 1219 Flamingo Drive
4b. City, Town, or Location of Death: Salisbury
4c. County of Death: Wicomico

Funeral Director

5. Social Security Number: 215-16-3660
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 76 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Feb 29, 1924
9. Birthplace (State or Foreign Country): MD

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: MD
10b. County: Wicomico
10c. City, Town or Location: Salisbury
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 1219 Flamingo Drive
10f. Zip Code: 21801
10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☐ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4 or 5+): 2
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Nurse
16b. Kind of Business/Industry: Hospital
17. Father's Name (First, Middle, Last): George Carr
18. Mother's Name (First, Middle, Maiden Surname): Etha Jones
19a. Informant's Name/Relationship (Type, Print): Ms. Elsie Shelton/Daughter
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 8053 Chelwynde Ave., Philadelphia, PA 19153
20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Macedonia U.M. Ch.
Date: Apr 3 2001
20c. Location - City or Town, State: Dames Quarter, MD
21. Signature of Funeral Service Licensee: Calvin L. Williams
22. Name and Address of Facility: Smith & Williams Funeral Home, P.A. 2818 East Baltimore Street Baltimore, MD

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Sudden cardiac death

Due to (or as a consequence of):
b. Coronary artery disease — 2 (yrs.)

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c. Non insulin dependent diabetes — 2 y.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☒ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☒ Residence 8☐ Other (Specify)
27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: John R McLean MD
29c. License number: D25 209
29d. Date signed (Month, Day, Year): 3/30/01
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): John R McLean MD 1315 S. Division St.

State Registrar

31. Date filed (Month, Day, Year): APR 04 2001
32. Registrar's Signature: Glenn G Speckhart Salisbury MD 21804

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 10288

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
George Lewis Johnson, Sr.	Apr 1, 2001	7:35 a.m. M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Oasys Eldercare, Inc.	Columbia	Howard

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
229-03-2811	1 M X 2 F	83 Yrs.			Jun 26, 1917	Virginia

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Virginia	Unk	Unk.	1 Yes 2 X No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
24 Hicksville Rd.	23076	U.S.A.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1 Never Married 2 X Married 3 Widowed 4 Divorced	1 Yes 2 X No If Yes, Give Year or Dates:	1 Yes 2 X No Specify:	Specify: Black

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementery/Secondary (0-12)	College (1-4or 5+)		
	2	Letter Carrier	U.S. Postal Service

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
George Johnson	Betty Lewis

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Mr. George Johnson, Jr.	3814 Glen Ave Baltimore, MD 21215

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1 Burial 2 Cremation 3 X Removal from State 4 Donetion 5 Other (Specify)	Forest Lawn Cemetery	04/07/01	Henrico, Virginia

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
MO1113	Slack Funeral Home, P.A. 3871 Old Columbia Pike Ellicott City, MD 21043

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Finel disease or condition resulting in death)	a. Stroke	Days
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of): Diabetes Mellitus	years
	c. Due to (or as a consequence of):	
	d. Due to (or as a consequence of):	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month Day Year
1 Yes 2 No 9 Unknown	1 Live birth 2 Fetel death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify) 9 Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?	24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1 Yes 2 No 3 Probably 4 X Unknown	1 Yes 2 X No	1 Yes 2 No

25. Was case referred to medical exeminer?	26. Place of Death (Check only one)	
1 Yes 2 X No	Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA	Other: 4 Nursing Home 5 Residence 6 X Other (Specify) Assisted Living

27. Menner of Death	28a. Dete of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work?	28d. Describe how injury occurred
1 X Naturel 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined			1 Yes 2 No	
	28e. Place of Injury - At home, farm, streat, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1 X **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as steted.
2 **Medical Examiner:** On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, dete and place, and due to tha cause(s) end manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
MD	D36786	April 3, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Jeffrey Katz M.D. 7061 Deepage Drive, Suite 104, Columbia MD

State Registrar

31. Dete filed (Month, Dey, Yeer)	32. Registrar's Signature
APR 04 2001	Jennifer D Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 10289

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): George A. Limmer
2. Date of Death: Month April Day 2 Year 2001
3. Time of Death: 10:19 AM
4a. Facility Name (If not institution, give street and number): Stella Maris Hospice
4b. City, Town, or Location of Death: Timonium
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 213-07-8684
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 90 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Sept. 30 1910
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Md
10b. County: Baltimore
10c. City, Town or Location: Parkville
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 7710 Wilson Ave.
10f. Zip Code: 21234
10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 College (1-4or 5+): —
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): machinist
16b. Kind of Business/Industry: Bethlehem Steel

17. Father's Name (First, Middle, Last): Anthony Limmer
18. Mother's Name (First, Middle, Maiden Surname): Frances Remy

19a. Informant's Name/Relationship (Type, Print): Mary Anna Limmer
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 7710 Wilson Ave. Baltimore, Md 21234

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Parkwood Cemetery
Date: April 5 2001
20c. Location - City or Town, State: Parkville, Md

21. Signature of Funeral Service Licensee: Kevin L Wells
22. Name and Address of Facility: Evans Funeral Chapel 8800 Harford Rd. Baltimore, Md 21234

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. COLON CANCER
Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No
26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [X] Other (Specify) HOSPICE
27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: [signature]
29c. License number: D43725
29d. Data signed (Month, Day, Year): 4/2/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): DR. TARIQ MAHMOOD 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093

State Registrar

31. Date filed (Month, Day, Year): APR 04 2001
32. Registrar's Signature: Geneva G Sparks

DHMH 16 Rev 6/95

ORIGINAL

To be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

APRIL 2, 2001 10:19 a.m.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Division of Vital Records, P.O. Box 68760,

GEORGE LIMMER

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 10290

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Stella M. Laughery
2. Date of Death (Month, Day, Year): April 2 2001
3. Time of Death: 1506
4a. Facility Name (If not institution, give street and number): The Johns Hopkins Hospital
4b. City, Town, or Location of Death: Baltimore City
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 209 24 1832
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 68 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Dec. 29, 1932
9. Birthplace (State or Foreign Country): Pennsylvania

Usual Residence of Decedent

10a. State: Maryland
10b. County: Anne Arundel
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 112 W. 2nd Avenue
10f. Zip Code: 21225
10g. Citizen of What Country?: U.S.

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4or 5+): 1 year
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use ratired): Clerk
16b. Kind of Business/Industry: C & O Railroad

17. Father's Name (First, Middle, Last): Michael Burack
18. Mother's Name (First, Middle, Maiden Surname): Barbara Shumar

19a. Informant's Name/Relationship (Type, Print): Kathleen Phelan / Daughter
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 507 Stamford Road Baltimore, Maryland 21229

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Meadowridge Memorial Park
Date: 4/5/01
20c. Location - City or Town, State: Baltimore, Maryland

21. Signature of Funeral Service Licensee: Donna M Zaminowski
22. Name and Address of Facility: Gonce Funeral Home P.A. 4001 Ritchie Highway Baltimore, Md. 21225

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Neutropenia — Days

Due to (or as a consequence of):
b. Waldenström's Macroglobulinemia — Weeks

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Hypotension, congestive heart failure, respiratory insufficiency, axonal neuropathy

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☒ Yes 2☐ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes ☒ No
26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day, Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): ☒ 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. ☐ 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: M. Hemstreet
29c. License number: Res 000
29d. Data signed (Month, Day, Year): April 2, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): M. Hemstreet, MD, PhD, 600 N. Wolfe St., Baltimore, MD 21287

State Registrar

31. Date filed (Month, Day, Year): APR 04 2001
32. Registrar's Signature: G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar AMND ITM#23a PER MD. G794 4-4-2001 JAB

Certificate of Death

Reg. No. 2001 10291

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)			2. Date of Death Month	Day	Year	3. Time of Death
JAMES		MCGEE	MARCH	29	2001	17:50 M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
The Johns Hopkins Hospital	Baltimore City	NA

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months	Days	If Under 24 Hrs.: Hours	Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
216-84-3143	XX 1 M 2 F	38 Yrs.					08-29-62	MD

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	NA	Baltimore	XX Yes 2 No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
1818 E. North Avenue	21213	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
XX 1 Never Married 2 Married 3 Widowed 4 Divorced	1 Yes XX 2 No If Yes, Give Year or Dates:	1 Yes XX 2 No Specify:	Specify: Black

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12th Grade	NA	Factory	John D. Lucas

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Pearlie Haywood McGee	Naomi Crank

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21213
Naomi McGee	1818 E. North Avenue Baltimore, Maryland

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1 XX Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)	King Mem. Gardens	04-03-01	Randallstown, MD

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
[signature]	Baltimore, Maryland 21202 WM.C.March FH 1101 E. North Avenue

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)	a. ASPIRATION PNEUMONIA	30 MINUTES
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of): b. CEREBROVASCULAR ACCIDENT	24 DAYS
	Due to (or as a consequence of): c. HYPERTENSION	YEARS
	Due to (or as a consequence of): d.	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month Day Year
1 Yes 2 No 9 Unknown	1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify) 9 Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

HIV, FAILURE TO THRIVE, HISTORY OF PULMONARY EMBOLISM, ASPIRATION PNEUMONIA, HIV DEMENTIA HEPATITIS C

23e. Did tobacco use contribute to the cause of death?	24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1 Yes 2 XX No 3 Probably 4 Unknown	1 Yes 2 XX No	1 Yes 2 XX No

Medical Certification: To Be Completed by Physician/Medical Examiner

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1 Yes 2 XX No	Hospital: 1 XX Inpatient 2 ER/Outpatient 3 DOA	Other: 4 Nursing Home 5 Residence 6 Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work?	28d. Describe how injury occurred
1 XX Natural 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined			1 Yes 2 No	
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 XX **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
[signature] Laura B Heppel MD	RES-000	MARCH 29, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Laura Heppel 600 N. Wolfe St. Nelson 106 Baltimore MD 21287

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
APR 04 2001	[signature]

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 10292

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): RUTH MARGARET MACKERETH
2. Date of Death Month 03 Day 30 Year 2001
3. Time of Death: 1312
4a. Facility Name (If not institution, give street and number): GENESIS CROMWELL NURSING HOME
4b. City, Town, or Location of Death: TOWSON
4c. County of Death: BALTIMORE

Funeral Director

5. Social Security Number: 213-10-5615
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 91 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 11/05/1909
9. Birthplace (State or Foreign Country): WEST VIRGINIA

Usual Residence of Decedent

10a. State: MD
10b. County: BALTIMORE
10c. City, Town or Location: CARNEY
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 19 ODEON COURT
10f. Zip Code: 21234
10g. Citizen of What Country: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 8th GRADE; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): SALES CLERK
16b. Kind of Business/Industry: McCROYS

17. Father's Name (First, Middle, Last): WILLIAM B. JOHNSTON
18. Mother's Name (First, Middle, Maiden Surname): BERTHA CULP

19a. Informant's Name/Relationship (Type, Print): LINDA L. BETZ/DAUGHTER
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 19 ODEON COURT CARNEY, MARYLAND 21234

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): MORELAND MEMORIAL PARK
Date: 4/4/01
20c. Location - City or Town, State: HILLENDALE, MD

21. Signature of Funeral Service Licensee: ▶ Heather S. Hay
22. Name and Address of Facility: THE JOHNSON FUNERAL HOME P.A. 8521 LOCH RAVEN BLVD. TOWSON, MD 21286

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. CHF	days
	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b.	
	Due to (or as a consequence of):	
	c.	
	Due to (or as a consequence of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
Prostate Dementia Recurrent Aspiration Pneumonia DVT

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown
24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)
27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: ▶ Raymundo
29c. License number: 054518
29d. Date signed (Month, Day, Year): 4/3/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Martha C. Raymundo 3007 E Northern Parkway Baltimore MD 21214

State Registrar

31. Date filed (Month, Day, Year): APR 04 2001
32. Registrar's Signature: ▶ Geneva G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

01-1728-510
mnmr
Tom Moore

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar AMEND#5 PER F.H. G794 4-6-2001 JB

Certificate of Death

Reg. No. 2001 10293

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
Thomas D. Moore	March 28, 2001	2132 M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Johns Hopkins Bayview Hospital	Baltimore	N/A

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
215 ~~72~~ 92 7066	1☒M 2☐F	37 Yrs.			Dec. 26, 1963	Maryland

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Anne Arundel	Pasadena	1☐Yes 2☒No

10e. Street and Number	10f. Zip Code	10g. Citizen of Whet Country?
697 - 207th Street	21122	U.S.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐Never Married 2☒Married 3☐Widowed 4☐Divorced	1☐Yes 2☒No If Yes, Give Year or Dates:	1☐Yes 2☒No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12	1 year	Electrician	Automobile

17. Father's Name (First, Middle, Last)	18. Mother's Neme (First, Middle, Maiden Surname)
Henry J. Moore	Patricia M. Thomas

19a. Informant's Neme/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
J. Lynn Moore / Wife	697 - 207th Street Pasadena, Maryland 21122

20a. Method of Disposition	20b. Placa of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒Bunal 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	Cedar Hill Cem.	4/2/01	Baltimore, Maryland

21. Signature of Funerel Service Licensee	22. Name and Address of Facility
George D. Gonce	Gonce Funeral Home P.A. 4001 Ritchie Highway Baltimore, Md. 21225

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications thet caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Finat disease or condition resulting in death)	a. Ruptured Ascending Aortic Aneurysm	
Sequentially list conditions, if eny, leeding to immediete cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequenca of):	
	c. Due to (or as a consequenca of):	
	d. Due to (or as a consequence of):	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1☐Yes 2☐No 9☐Unknown	23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnent at time of deeth 5☐Other (specify) 9☐Unknown	23d. Dete of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobecco use contribute to the cause of death?	24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐Yes 2☒No 3☐Probably 4☐Unknown	1☒Yes 2☐No	1☒Yes 2☐No

25. Was case referred to medical exeminer?	26. Place of Death (Check only one)	
1☒Yes 2☐No	Hospital: 1☐Inpatient 2☒ER/Outpatient 3☐DOA	Other: 4☐Nursing Home 5☐Residenca 8☐Other (Specify)

27. Manner of Death	28a. Dete of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒Neturat 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined		M	1☐Yes 2☐No	
	28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one)
1☐ **Certifying Physician:** To the best of my knowledge, death occurred et the time, date and place, and due to the cause(s) and manner as steted.
2☒ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) end manner steted.

29b. Signature and title of certifier	29c. Licanse number	29d. Date signed (Month, Day, Year)
Robert Reed	O.C.M.E.	March 29, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
J. Hollowell, MD 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
APR 04 2001	Denise G Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

01-1797-510
mnmr
Donald MacCullum

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar AMENDED ITEMS# 23a,ptII,28a-f per ME G797 070901 SS *Certificate of Death* Reg. No. 2001 10294

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
Donald Malcom MacCallum	April 02, 2001	1546 pM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Good Samaritan Hospital	Baltimore	N/A

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
212-20-2503	1☒M 2☐F	77 Yrs.			Nov. 20, 1923	Maryland

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	N/A	Baltimore	1☒Yes 2☐No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
4914 Morello Road	21214	United States

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☒Never Married 2☐Married 3☐Widowed 4☐Divorced	1☒Yes 2☐No If Yes, Give Year or Dates: WWII	1☐Yes 2☒No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	18b. Kind of Business/Industry
Elementery/Secondery (0-12)	College (1-4or 5+)		
12 yrs.		Inspector	Baltimore City

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Malcolm MacCallum	Ethel M. Carlin

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Elaine R. Ivins / Cousin	1306 Dellwood Avenue Baltimore, Maryland 21211

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other piece)	Date	20c. Location - City or Town, State
1☒Burial 2☐Cremation 3☐Removal from State 4☐Donetion 5☐Other (Specify)	Parkwood Cemetery	April 9, 2001	Baltimore, Maryland

21. Signeture of Funeral Service Licensee	22. Name and Address of Facility
▶ Michael E. Canapp	LEONARD J. RUCK, INC. 5305 Harford Road Baltimore, MD 21214

Physician /Medical Examiner

23a. Part I. Enter the disease, or complicetions that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. HEAD INJURIES

Approximate Interval Between Onset and Death

Immediate Cause (Finat disease or condition resulting in death): a. ~~Intracerebral Hemorrhage~~ Depressed Skull Fracture

Due to (or es e consequence of):

Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequenca of):

c. Due to (or as a consequence of):

d.

If FEMALE: 23b. Was decedent pregnent in the pest 12 months?	23c. If yes, outcome of pregnancy	23d. Dete of delivery Month Day Year
1☐Yes 2☐No 9☐Unknown	1☐Live birth 2☐Fetal death 3☐Ectopic pregnency 4☐Pregnent at time of death 5☐Other (specify) 9☐Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Diabetes Mellitus

Atherosclerotic Cardiovascular Disease

23e. Did tobacco use contribute to the cause of death?	24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐Yes 2☒No 3☐Probably 4☐Unknown	1☒Yes 2☐No	1☒Yes 2☐No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☒Yes 2☐No	Hospital: 1☐Inpatient 2☒ER/Outpatient 3☐DOA	Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

Medical Certification; To Be Completed by Physician/Medical Examiner

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☐Naturel 2☒Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined	4-2-01	1 PM	1☐Yes 2☒No	subject fell

28e. Place of Injury - At home, farm, street, factory, offica building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)
home	4914 Morello Rd., Baltimore, MD

29a. Certifier (Check only one)
1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☒ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶	O.C.M.E.	April 03, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Julian Locke, MD 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
APR 0 4 2001	▶ Bonnie G Sparks

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar Amend Item#17 perFHG794 4/4/01 EW **Certificate of Death**

Reg. No. 2001 10295

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
Julia Ann Morris	Apr 3, 2001	7:45 AM M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Heartlands Senior Living Village	Ellicott City	Howard

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
232-16-8019	1☐M 2☒F	85 Yrs.			Apr 22, 1915	West Virginia

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Howard	Ellicott City	1☐Yes 2☒No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
3004 North Ridge Road Apt. 410	21043	U.S.A.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐Never Married 2☐Married 3☒Widowed 4☐Divorced	1☐Yes 2☒No If Yes, Give Year or Dates:	1☐Yes 2☒No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12		Assembler	Western Electrical

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
John ~~Unknown~~ Posick	Emma Unknown

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Mr. John H. Morris	7862 Mayfield Avenue Elkridge, Maryland 21075

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☐Burial 2☒Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	All County Cremation Services, Inc.	04/04/01	Sykesville, Maryland

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ [signature] M01113	Slack Funeral Home, P.A. ~~3871 Old Columbia Pike Ellicott City, MD 21043~~

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Pulmonary Hypertension	
Due to (or as a consequence of):	b. malignant Hypertension	20y
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c.	
Due to (or as a consequence of):	d.	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month Day Year
1☐Yes 2☒No 9☐Unknown	1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) _____ 9☐Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Renal Insufficiency

Diabetes, adult onset

Congestive heart failure

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☒~~Unknown~~

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐Yes 2☒~~No~~	1☐Yes 2☐No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐Yes 2☒~~No~~	Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA	Other: 4☐Nursing Home 5☐Residence 6☐~~Other~~ (Specify) Assisted Living

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒~~Natural~~ 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined		M	1☐Yes 2☐No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification; To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one) 1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ [signature] MD	D35309	4 13 101

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2850 N Ridge Rd. Ellicott City, MD 21043

7

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
APR 04 2001	▶ Geneva G Sparks

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23e or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 10296

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): MARTINA MILLS
2. Date of Death — Month: MARCH Day: 30 Year: 01
3. Time of Death: 250 PM
4a. Facility Name (If not institution, give street and number): University of Maryland Medical System
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: Baltimore County

Funeral Director

5. Social Security Number: 215-76-9783
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 39 Yrs.
If Under 1 Year — Months: Days:
If Under 24 Hrs. — Hours: Min.:
8. Date of Birth (Month, Day, Year): April 12, 1961
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: N/A
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 1715 Madison Ave.
10f. Zip Code: 21217
10g. Citizen of What Country?: USA

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed) — Elementary/Secondary (0-12): 12 College (1-4or 5+): 0
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Cook
16b. Kind of Business/Industry: Private Industry

17. Father's Name (First, Middle, Last): Andy Heggins
18. Mother's Name (First, Middle, Maiden Surname): Annie Morris

19a. Informant's Name/Relationship (Type, Print): Ms. Cynthia A. Mills (sister)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2217 Druid Hill Ave. Apt. 2 Balto. Md. 21217

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Mt. Zion
Date: 4/7/2001
20c. Location - City or Town, State: Lansdowne, Md.

21. Signature of Funeral Service Licensee: ▶ Joseph L. Russ
22. Name and Address of Facility: Joseph L. Russ Funeral Home 2222 W. North Ave. Balto. Md. 21216

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death):
a. Sepsis
Due to (or as a consequence of):
b. Congestive Heart Failure, class 4

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c. Renal Failure
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one) — Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)
27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ JK Mussomeli MD
29c. License number: P14674
29d. Date signed (Month, Day, Year): 3/30/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): JUSTIN K MUSSOMELI, UMMS 22 South Greene St. Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year): APR 04 2001
32. Registrar's Signature: ▶

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Amned Items#2,23a,perPHYG798 8/7/01 EW

Certificate of Death

Reg. No. 2001 10297

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): PATRICIA E. NICHOLSON

2. Date of Death: Month 03 Day 29 Year 2001

3. Time of Death: 4:50 AM

4a. Facility Name (If not institution, give street and number): WESLEY HOUSE

4b. City, Town, or Location of Death: baltimore

4c. County of Death:

Funeral Director

5. Social Security Number: 216-30-9187

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 65 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Aug 2, 1935

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: MD

10b. County:

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 2211 W. Rogers Avenue

10f. Zip Code: 21209

10g. Citizen of What Country? USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: white

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4or 5+): 4

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): executive assistant

16b. Kind of Business/Industry: police department

17. Father's Name (First, Middle, Last): Michael Edward Molloy

18. Mother's Name (First, Middle, Maiden Surname): Mary Alice Madigan

19a. Informant's Name/Relationship (Type, Print): Danielle Nicholson/daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 26 York Court Baltimore, MD 21218

20a. Method of Disposition: 1☐ Burial 2☐ Cremation 3☐ Removal from State 4☒ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place):

Date:

20c. Location - City or Town, State:

21. Signature of Funeral Service Licensee: Ronald S. Wade, Director

22. Name and Address of Facility: State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201

To Be Completed by Funeral Director

Nicholson, Patricia E.

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Stroke — 10 days

Due to (or as a consequence of): ATHEROSCLEROTIC CARDIOVASCULAR DISEASE

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Metastatic Breast Cancer - S/p resection of Brain Metastasis followed by radiation therapy

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

Medical Certification: To Be Completed by Physician/Medical Examiner

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☑ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year):

28b. Time of Injury: M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred:

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify):

28f. Location (Street and Number or Rural Route Number, City or Town, State):

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

29a. Certifier (Check only one): 1☑ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: William D. McConnell MD

29c. License number: D42129

29d. Date signed (Month, Day, Year): March 29, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): William D. McConnell 500 W. University Baltimore 21210

State Registrar

31. Date filed (Month, Day, Year): APR 0 4 2001

32. Registrar's Signature: Jeanne G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

Amend Item 23aper FH04/04/01G794dhb

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 10298

Physician /Medical Examiner

1. Decedent's Nema (First, Middle, Last)	2. Dete of Deeth Month	Dey	Year	3. Time of Deeth
ELSIE N. NELSON	MARCH	22	01	6:15AM

4e. Facility Neme (If not institution, give street end number)	4b. City, Town, or Location of Deeth	4c. County of Death
St. Elizabeth's Nursing Home	Baltimore	

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthdey)	If Under 1 Year: Months	Days	If Under 24 Hrs.: Hours	Min.	8. Dete of Birth (Month, Dey, Yeer)	9. Birthplece (Stete or Foreign Country)
216-10-5827	1☐ M 2☒ F	88 Yrs.					April 9, 1912	Maryland

Usuel Residence of Dacedent

10a. Stata	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Baltimore	Baltimore	1☐ Yes 2☒ No

10e. Street and Number	10f. Zip Code	10g. Citizen of Whet Country?
108 Starhill Lane	21228	USA

11. Marital Status	12. Wes Decedant Evar in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yas or No- If Yas, specify Cuban, Maxican, Puerto Rican, etc.)	14. Race - American Indien, Bleck, White, etc.
1☐ Navar Married 2☐ Married 3☒ Widowed 4☐ Divorced	1☐ Yes 2☒ No If Yes, Give Year or Dates:	1☐ Yes 2☒ No Specify:	Specify: White

15. Decedent'a Education (Specify only highest grade completed)		16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondery (0-12)	College (1-4or 5+)		
8		Cashier	Grocery Store

17. Father's Neme (First, Middle, Last)	18. Mother's Neme (First, Middle, Meiden Sumeme)
Harry Wholey	Grace Butler

19e. Informent'a Neme/Reletionship (Type, Print)	19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code)
David L. Nelson (Son)	108 Starhill Lane, Baltimore, MD 21228

20e. Method of Disposition	20b. Piece of Disposition (Neme of cemetery, cremetory or other piece)	Dete	20c. Location - City or Town, Stete
1☒ Burial 2☐ Cremation 3☐ Remaval from Stete 4☐ Donetion 5☐ Other (Specify)	Loudon Park Cemetery	3/24/01	Baltimore, Maryland

21. Signeture of Funerel Servica Licensee	22. Nema and Addrass of Facility
	Loudon Park Funeral Home 3620 Wilkens Ave., Baltimore, MD 21229

Physician /Medical Examiner

23a. Part I. Enter the diseasa, or complications thet caused the deeth. Do not enter the mode of dying, such es cardiec or respiretory errest, shock, or heert feilure. List only one ceuse on eech line.

		Approximete Intervel Between Onset and Deeth
immediate Ceuse (Finel disease or condition resulting in deeth)	a. ~~Respiratory tract obstruction due to aspiration~~ Agonal Terminal Aspiration	hours
	Due to (or es a consequence of):	
Sequentielly list conditions, if any, leeding to Immediete cause. Enter Underlying Cause (Diseese or injury that Initieted events resulting in deeth) Lest	b. Due to (or es e consequence of):	
	c. Due to (or es e consequence of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Cerebrovascular Accident, Multi-Infarct dementia

Hypertension

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24e. Wes en autopsy performed?	24b. Were eutopsy findings aveilable prior to completion of cause of deeth?
1☐ Yes 2☒ No	1☐ Yes 2☐ No

25. Wes case referred to medical exeminer?	26. Piece of Deeth (Check only one)	
1☐ Yes 2☒ No	Hospitel: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA	Other: 4☒ Nursing Home 5☐ Residence 8☐ Other (Specify)

27. Menner of Deeth	28e. Dete of Injury (Month, Dey Yeer)	28b. Time of Injury	28c. Injury et Work?	28d. Describe how injury occurred
1☒ Netural 2☐ Accident 3☐ Sulcide 4☐ Homlcide 5☐ Pending investigation 6☐ Could not be determined		M	1☐ Yes 2☐ No	
	28e. Piece of Injury - At home, farm, street, fectory, office building, etc. (Specify)			28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one) 1☒ **Certifying Physician**: To the best of my knowledge, deeth occurred et tha time, dete end piece, end due to the cause(a) end menner as steted.
2☐ **Medicat Examiner:** On the besis of examinetion end/or Investigetion, in my opinion, deeth occurred at the time, date and place, end due to the cause(s) end menner stated.

29b. Signature and title of certifier	29c. Licensa number	29d. Data signed (Month, Day, Year)
B Lee physician	D52544	March 22, 2001

30. Neme end eddress of person who completed cause of deeth (Item 23e) (Type, Print)

Benjamin S. Lee, M.D., 700 Geipe Rd #204, Catonsville, MD 21228

State Registrar

31. Dete filed (Month, Dey, Yeer)	32. Registrer's Signeture
APR 04 2001	Geneva G Sparks

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that tha death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print In Black Indellble Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Amend Item#25 perPHYG794 4/27/01 EW

Certificate of Death

Reg. No. 2001 10299

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: JOHN WEBSTER OLGEIRSON

2. Date of Death (Month, Day, Year): April 2, 2001

3. Time of Death: 9:20 am

4a. Facility Name *(If not institution, give street and number)*: Union Memorial Hospital

4b. City, Town, or Location of Death: Baltimore

4c. County of Death:

Funeral Director

5. Social Security Number: 502-07-5491

6. Sex: 1☒ M 2☐ F

7. Age *(In yrs. last birthday)*: 85 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Jan 4, 1916

9. Birthplace *(State or Foreign Country)*: North Dakota

Usual Residence of Decedent

10a. State: MD

10b. County:

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 5008 Boxhill Lane

10f. Zip Code: 21210

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☒ Yes 2☐ No If Yes, Give Year or Dates: '41-46

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* white

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12; College (1-4or 5+): 4

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: civil engineer

16b. Kind of Business/Industry: dredging

17. Father's Neme *(First, Middle, Last)*: Gunnar Olgeirson

18. Mother's Name *(First, Middle, Maiden Surname)*: Isabel Hagan

19e. Informant's Name/Relationship *(Type, Print)*: Barbara Olgeirson/spouse

19b. Malling Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 5008 Boxhill Lane Baltimore, MD 21210

20a. Method of Disposition: 1☐ Buriel 2☐ Cremetion 3☐ Removal from State 4☒ Donation 5☐ Other *(Specify)*

20b. Placa of Disposition *(Name of cemetery, cremetory or other place)*:

Date:

20c. Location - City or Town, State:

21. Signature of Funeral Service Licensee: Ronald S. Wade, Director

22. Name and Address of Facility: State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiretory arrest, shock, or heart failure. List only one ceuse on each line.

Approximate Interval Between Onset and Deeth

Immediate Cause (Final disease or condition resulting in death)

a. Myocardial Infarction — minutes

Due to (or as a consequence of):

b. Arteriosceratic cardiovascular Disease — years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initieted events resulting in death) Last

Due to (or as e consequenca of):

c.

Due to (or as e consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

chronic obstructive pulmonary disease, chronic renal failure, anemia, compression fracture lumbar

23b. Did tobacco use contribute to the cause of death? 1☑ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were eutopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☒ Yes 2☐ No

26. Piece of Deeth *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☑ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*:

28b. Time of Injury: M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred:

28e. Piece of Injury - At home, farm, street, factory, offica buiiding, etc. *(Specify)*:

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*:

29a. Certifier *(Check only one)*: 1☑ **Certifying Physician:** To the best of my knowledge, deeth occurred at the time, date and piece, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and piece, end due to the ceuse(s) and manner stated.

29b. Signature and title of certifier: Donald J Weglein MD

29c. License number: D26394

29d. Date signed *(Month, Day, Year)*: 4/2/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Donald T. Weglein, MD 220 W. Coldspring Lane Baltimore, MD 21210

State Registrar

31. Date filed *(Month, Day, Year)*: APR 04 2001

32. Registrar's Signature: Barbara G Sparks

DHMH 16 Rev 6/95

ORIGINAL

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 10300

PETRELLA, VINCENT

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Vincent J. Petrella, Sr.
2. Date of Death Month: April Day: 1 Year: 2001
3. Time of Death: 6:48 P.M.
4a. Facility Name *(If not institution, give street and number)*: Franklin Square Hospital Center
4b. City, Town, or Location of Death: Rosedale
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 213-07-3353
6. Sex: 1 ☒ M 2 ☐ F
7. Age *(In yrs. last birthday)*: 89 Yrs. If Under 1 Year: Months / Days. If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: Sept 29, 1911
9. Birthplace *(State or Foreign Country)*: Pennsylvania

Usual Residence of Decedent

10a. State: Md
10b. County: Baltimore
10c. City, Town or Location: Perry Hall
10d. Inside City Limits: 1 ☐ Yes 2 ☒ No
10e. Street and Number: 9315 Seven Courts Dr
10f. Zip Code: 21236
10g. Citizen of What Country?: USA

11. Marital Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 10 College (1-4or 5+): —
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Sheet metal mechanic
16b. Kind of Business/Industry: Bethlehem Steel

17. Father's Name *(First, Middle, Last)*: Dominic Petrella
18. Mother's Name *(First, Middle, Maiden Surname)*: Julia Montanaro

19a. Informant's Name/Relationship *(Type, Print)*: Nancy Petrella wife
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 9315 Seven Courts Dr. Perry Hall, Md 21236

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Holy Redeemer Cemetery
Date: April 5 2001
20c. Location - City or Town, State: Baltimore, Maryland

21. Signature of Funeral Service Licensee: ▶ Krista S. Wells
22. Name and Address of Facility: Evans Funeral Chapel 8800 Harford Rd. Baltimore Md 21234

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than 'natural', or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. SEPSIS	
	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. PNEUMONIA	
	Due to (or as a consequence of):	
	c.	
	Due to (or as a consequence of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: MYOCARDIAL INFARCTION

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☑ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No
26. Place of Death *(Check only one)*: Hospital: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other *(Specify)*
27. Manner of Death: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 ☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Y. Barker MD
29c. License number: RD 192732
29d. Date signed *(Month, Day, Year)*: 04/01/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): DR. LANCE BARKER 9000 FRANKLIN SQUARE DRIVE BALTIMORE, MD. 21237

State Registrar

31. Date filed *(Month, Day, Year)*: APR 04 2001
32. Registrar's Signature: ▶ Geneva G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 10301

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Mary Elizabeth Pickett
2. Date of Death: Month April Day 3 Year 2001
3. Time of Death: 1:45 A M
4a. Facility Name (If not institution, give street and number): Dulaney - Towson Nurs. Cntr
4b. City, Town, or Location of Death: TOWSON
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 212-05-2930
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 90 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Oct 30 1910
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Md
10b. County: Baltimore
10c. City, Town or Location: Parkville
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 28 Bristow Ct.
10f. Zip Code: 21234
10g. Citizen of What Country? USA

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+): —
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Clerk
16b. Kind of Business/Industry: Baltimore Gas & Electric

17. Father's Name (First, Middle, Last): William I. Pickett
18. Mother's Name (First, Middle, Maiden Surname): Elizabeth S. Driver

19a. Informant's Name/Relationship (Type, Print): Karen E. Huggins
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 28 Bristow Ct. Baltimore Md 21234

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Poplar Springs Cemo. Date: April 6 2001
20c. Location - City or Town, State: Mt. Airy Maryland

21. Signature of Funeral Service Licensee: Krista L Wells
22. Name and Address of Facility: Evans Funeral Chapel 8800 Harford Rd. Baltimore, Md 21234

Physician /Medical Examiner

29a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Dehydration
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. Dementia
Due to (or as a consequence of):
c. Parkinson's disease
Due to (or as a consequence of):
d.

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐ Yes 2☒ No 9☐ Unknown
23c. If yes, outcome of pregnancy: 1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) 9☐ Unknown
23d. Date of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
CAD
PUD
S/p UTI

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown
24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)
27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
26c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
26e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification; To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Rachelle Gajadhar, MD
29c. License number: D56705
29d. Date signed (Month, Day, Year): 4/3/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Dr. Rachelle Gajadhar 3007 E. Northern Pkwy Baltimore, Md

State Registrar

31. Date filed (Month, Day, Year): APR 04 2001
32. Registrar's Signature: Jennie G Sparks

To be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Physician /Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 10302

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death (Month, Day, Year)	3. Time of Death
JULIA C. PINCOFFS	MARCH 23, 2001	10:50 AM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
11 Cedar Point Road	Severna Park	Anne Arundel

Funeral Director

5. Social Security Number	8. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	6. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
216-30-0638	1☐M 2☒F	73 Yrs.			Aug 31, 1927	Korea

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	Anne Arundel	Severna Park	1☐Yes 2☒No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
11 Cedar Point Road	21146	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Rece - American Indian, Black, White, etc.
1☐Never Married 2☒Married 3☐Widowed 4☐Divorced	1☐Yes 2☒No If Yes, Give Year or Dates:	1☐Yes 2☒No Specify:	Specify: white

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12	5	housewife	none

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Archilbald S. Chalfont	Julia Merriken

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Peter Pincoffs/spouse	11 Cedar Point Road Severna Park, MD 21146

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☐Burial 2☐Cremation 3☐Removal from State 4☒Donetion 5☐Other (Specify)			

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
Ronald S. Wade, Director	State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feilure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Finel disease or condition resulting in death)	a. Brain tumor (Oligodendroglioma)	6 mos
Sequentially list conditions, if any, leeding to immediete cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of):	
	c. Due to (or as a consequence of):	
	d. Due to (or as a consequence of):	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery (Month, Day, Year)
1☐Yes 2☐No 9☐Unknown	1☐Live birth 2☐Fetel deeth 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) _____ 9☐Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐Yes 2☒No	1☐Yes 2☐No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐Yes 2☒No	Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA	Other: 4☐Nursing Home 5☒Residence 6☐Other (Specify)

27. Manner of Death	26a. Date of Injury (Month, Day Year)	26b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined		M	1☐Yes 2☐No	

26e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	26f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one)
1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
J. Selonich MD	D19838	3/26/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Stuart E. Selonich, MD 900 Bestgate Annapolis, Md.

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
APR 04 2001	G Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 10303

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): W. MORGAN PARKHURST
2. Date of Death: Month 03 Day 30 Year 01
3. Time of Death: 10:38 am
4a. Facility Name (If not institution, give street and number): ROCK SPRING VILLAGE
4b. City, Town, or Location of Death: FOREST HILL
4c. County of Death: HARFORD

Funeral Director

5. Social Security Number: 216-09-1376
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 92 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 09/19/1908
9. Birthplace (State or Foreign Country): MARYLAND

Usual Residence of Decedent

10a. State: MD
10b. County: BALTIMORE
10c. City, Town or Location: MILLERS
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 19719 GUNPOWDER ROAD
10f. Zip Code: 21102
10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 9th GRADE | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): PAINTER
16b. Kind of Business/Industry: CONTRACTOR

17. Father's Name (First, Middle, Last): WALTER C. PARKHURST
18. Mother's Name (First, Middle, Maiden Surname): ELSIE MORGAN

19a. Informant's Name/Relationship (Type, Print): DAVID M. PARKHURST/SON
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 19719 GUNPOWDER ROAD MILLERS, MARYLAND 21102

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): PARKWOOD CEMETERY
Date: 4/3/01
20c. Location - City or Town, State: BALTIMORE, MD

21. Signature of Funeral Service Licensee: Heather N. Hay
22. Name and Address of Facility: THE JOHNSON FUNERAL HOME P.A. 8521 LOCH RAVEN BLVD. TOWSON, MD 21286

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. (Approximate Interval Between Onset and Death)

Immediate Cause (Final disease or condition resulting in death): a. myocardial infarction
Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last:
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: emphysema, pneumonia, dementia

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No
26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | Other: 4 [X] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [ ] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: David S. Dunn
29c. License number: D32291
29d. Date signed (Month, Day, Year): March 30, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): DAVID S. DUNN D.O. F.C.C.W. MAC PHAIL

State Registrar

31. Date filed (Month, Day, Year): APR 0 4 2001
32. Registrar's Signature: Geneva G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 10304

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Pinit Pangsanthia
2. Date of Death Month Day Year: April 1, 2001
3. Time of Death: 10:15 AM
4a. Facility Name *(If not institution, give street and number)*: University of Maryland
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: Baltimore City

Funeral Director

5. Social Security Number: 213-37-8028
6. Sex: 1 ☒ M 2 ☐ F
7. Age *(In yrs. last birthday)*: 52 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: Aug. 12, 1948
9. Birthplace *(State or Foreign Country)*: Thailand

Usual Residence of Decedent

10a. State: Maryland
10b. County: Anne Arundel
10c. City, Town or Location: Annapolis
10d. Inside City Limits: 1 ☒ Yes 2 ☐ No
10e. Street and Number: 1014 West Street
10f. Zip Code: 21401
10g. Citizen of What Country?: Thailand

11. Marital Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No — If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 ☐ Yes 2 ☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* Asian

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 10th — College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Baker
16b. Kind of Business/Industry: Bakery

17. Father's Name *(First, Middle, Last)*: Yang Pangsanthia
18. Mother's Name *(First, Middle, Maiden Surname)*: Pan Tipsanthia

19a. Informant's Name/Relationship *(Type, Print)*: Titha Pangsanthia / wife
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 1014 West Street, Annapolis, Maryland 21401

20a. Method of Disposition: 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Metro Crematory, Inc.
Date: 04/03 2001
20c. Location - City or Town, State: Baltimore, Maryland

21. Signature of Funeral Service Licensee: ▶ Michele G. Kutta
22. Name and Address of Facility: Hardesty Funeral Home, P.A. 12 Ridgely Ave., Annapolis, MD 21401

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Esophageal Cancer
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☒ Yes 2 ☐ No
26. Place of Death *(Check only one)*: Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☒ DOA — Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other *(Specify)*

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 8 ☐ Could not be determined
28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 ☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Arthur Perpall M.D.
29c. License number: D27450
29d. Date signed *(Month, Day, Year)*: April 1, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): 22 South Greene Street Baltimore, Maryland

State Registrar

31. Date filed *(Month, Day, Year)*: APR 0 4 2001
32. Registrar's Signature: ▶ Renee G Sparks

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 10305

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: **John Jackson Platter**

2. Date of Death (Month, Day, Year): Mar 31, 2001

3. Time of Death: 3:15 a.m.

4a. Facility Name *(If not institution, give street and number)*: Gilchrist Hospice Center

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: Baltimore City

Funeral Director

5. Social Security Number: 491-32-3005

6. Sex: 1 ☐ M 2 ☒ F

7. Age *(In yrs. last birthday)*: 69 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: May 24, 1931

9. Birthplace *(State or Foreign Country)*: Missouri

Usual Residence of Decedent

10a. State: Maryland

10b. County: Howard

10c. City, Town or Location: Columbia

10d. Inside City Limits: 1 ☐ Yes 2 ☒ No

10e. Street and Number: 6662 Mohawk Court

10f. Zip Code: 21046

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 ☒ Yes 2 ☐ No If Yes, Give Year or Dates: 1951 1955

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12) | College (1-4or 5+): 4+

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Assistant Deputy Dir.- NSA

16b. Kind of Business/Industry: US Government

17. Father's Name *(First, Middle, Last)*: John Jackson Platter

18. Mother's Name *(First, Middle, Maiden Surname)*: Pearlie Keeney

19a. Informant's Name/Relationship *(Type, Print)*: Ms. Laura Platter

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 6662 Mohawk Court Columbia, Maryland 21046

20a. Method of Disposition: 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: All County Cremation Services, Inc.

Date: 04/02/01

20c. Location - City or Town, State: Sykesville, Maryland

21. Signature of Funeral Service Licensee: [signature] 100535

22. Name and Address of Facility: Slack Funeral Home, P.A. 3871 Old Columbia Pike Ellicott City, MD 21043

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Platter, John 3/31/01 3:15 am

Physician /Medical Examiner

29a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. pancreatic cancer — one year

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No

26. Place of Death *(Check only one)*: Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other *(Specify)* Hospice

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

29a. Certifier *(Check only one)*: 1 ☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature]

29c. License number: D25205

29d. Date signed *(Month, Day, Year)*: March 31, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): W. A. Riley GBMC 6701 N. Charles St. Balto. MD 21204

15

State Registrar

31. Date filed *(Month, Day, Year)*: APR 0 4 2001

32. Registrar's Signature: [signature] Geneva G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 10306

Physician /Medical Examiner

1. Decedent's Neme (First, Middle, Last): STELLA PATTON
2. Dete of Death — Month: April Day: 2 Year: 2001
3. Time of Death: 13:46
4e Facility Name (If not institution, give street and number): The Johns Hopkins Hospital
4b. City, Town, or Location of Death: Baltimore City
4c. County of Deeth: N/A

Funeral Director

5. Social Security Number: 215-05-9894
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 86 Yrs. — If Under 1 Year: Months / Deys — If Under 24 Hrs.: Hours / Min.
8. Dete of Birth (Month, Day, Year): April 14, 1914
9. Birthplace (State or Foreign Country): Poland

Usual Residence of Decedent

10a. Stete: Md.
10b. County: N/A
10c. City, Town or Location: Baltimore City
10d. Inside City Limits: 1☒ Yes 2☐ No
10a. Street and Number: 227 South Robinson Street
10f. Zip Code: 21224
10g. Citizen of What Country?: USA

11. Meritel Stetus: 1☐ Never Married 2☐ Merried 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yeer or Detes:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indien, Bleck, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementery/Secondery (0-12): 6 yrs. College (1-4or 5+):
16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired): Seamstress
16b. Kind of Business/Industry: Clothing

17. Father's Name (First, Middle, Last): Francis Antkoviak
18. Mother's Neme (First, Middle, Maiden Surname): Agnes Antkoviak

19e. Informent's Neme/Reletionship (Type, Print): Anthony Lorbiecki Sr. son
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 234 South Robinson Street, Baltimore, Md. 21224

20a. Method of Disposition: 1☒ Burial 2☐ Cremetion 3☐ Removel from Stete 4☐ Donetion 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other piece): St. Stanislaus Cemetery
Dete: April 6 2001
20c. Location - City or Town, Stete: Baltimore, Md.

21. Signature of Funeral Service Licensee: John E. Connelly Jr.
22. Name and Address of Facility: Connelly Funeral Home of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, Md. 21222

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such es cardiac or respiratory errest, shock, or heert failure. List only one ceuse on eech line.

		Approximete Interval Between Onset end Deeth
Immedlete Ceuse (Finel diseese or condition resulting in deeth) a.	Stroke.	14 days
Due to (or es a consequence of):		
b.	Hypertension	years
Sequentially list conditions, if any, leeding to immediete cause. Enter Underlying Cause (Diseese or Injury thet initiated events resulting in deeth) Last — Due to (or es e consequence of): c.	Atrial Fibrillation	years
Due to (or as e consequence of): d.	Pulmonary edema	10 days

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Pert I.: left hemiparesis

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Wes en eutopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Deeth (Check only one): Hospitel: 1☒ Inpetient 2☐ ER/Outpetient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Menner of Deeth: 1☒ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined

28a. Dete of Injury (Month, Dey Yeer)
28b. Time of Injury M
28c. Injury et Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Plece of injury - At home, ferm, street, fectory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29e. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, date and plece, and due to the cause(s) end manner as stated. 2☐ **Medicel Examiner:** On the basis of examinetion and/or investigetion, in my opinion, deeth occurred et the time, date end place, and due to the cause(s) and menner steted.

29b. Signeture and title of certifier: Jeannette M. Liu, MD.
29c. License number: RES-000
29d. Date signed (Month, Day, Year): April 02, 2001

30. Neme and eddress of person who completed cause of death (Item 23a) (Type, Print): Jeannette M. Liu, 600 N. Wolfe St., Baltimore, MD 21287

State Registrar

31. Dete filed (Month, Day, Year): APR 04 2001
32. Registrar's Signeture: Penny L. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 10307

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Hazel Phillips

2. Date of Death: Month: APRIL Day: 1, Year: 2001

3. Time of Death: 945pm

4a. Facility Name (If not institution, give street and number): Maryland General Hospital

4b. City, Town, or Location of Death: Baltimore City

4c. County of Death: N/A

Funeral Director

5. Social Security Number: 214-40-3836

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 91 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Nov. 11, 1909

9. Birthplace (State or Foreign Country): Virginia

Usual Residence of Decedent

10a. State: Maryland

10b. County: N/A

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 1505 N. Bentalou St.

10f. Zip Code: 21216

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever In U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: Afro-American

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 College (1-4or 5+): 4

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Music Teacher

16b. Kind of Business/Industry: Education

17. Father's Name (First, Middle, Last): Albert J. Mitchell

18. Mother's Name (First, Middle, Maiden Surname): Mamie Jones

19a. Informant's Name/Relationship (Type, Print): Mrs. Anastatia Benton (daughter)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4314 Wentworth Rd, Balto, Md. 21207

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Arbutus Mem. Park

Date: 4/6/2001

20c. Location - City or Town, State: Balto. Md.

21. Signature of Funeral Service Licensee: Joseph L. Russ

22. Name and Address of Facility: Joseph L. Russ Funeral Home 2222 W. North Ave. Balto. Md. 21216

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiretory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Acute Stroke

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Cardiac Arrhythmia

Due to (or as a consequence of):

c. Atherosclerotic Heart Disease

Due to (or as e consequence of):

d.

Part ff. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Wes en autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the besis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signeture and title of certifier: Constance Ndiaguiba MD

29c. License number: P 14582

29d. Date signed (Month, Day, Year): 4/1/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Constance Ndiaguiba, M.D. C/o Maryland General Hospital

State Registrar

31. Date filed (Month, Day, Year): APR 04 2001

32. Registrar's Signature: Geneva D Sparks

To be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Hazel Phillips

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

1- For State Registrar

Reg. No. 2001 10308

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): FANNIE ROGERS

2. Date of Death Month: MARCH Day: 30th Year: 2001

3. Time of Death: 6:55 P M

4a. Facility Name (If not institution, give street and number): MERCY MEDICAL CENTER 301 ST. PAUL PLACE

4b. City, Town, or Location of Death: BALTIMORE

4c. County of Death: N/A.

Funeral Director

5. Social Security Number: 213-26-7717

8. Sex: 1☐M 2☒F

7. Age (In yrs. last birthday): 68 Yrs.

If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): 04-27-32

9. Birthplace (State or Foreign Country): MD

Usual Residence of Decedent

10a. State: MD

10b. County: NA

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1☐Yes 2☐No XX

10e. Street and Number: 2210 E. Fayette Street

10f. Zip Code: 21231

10g. Citizen of What Country?: USA

11. Marital Status: 1☐Never Married 2☒Married 3☐Widowed 4☐Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐Yes 2☒No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No Specify:

14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 12th Grade

College (1-4or 5+): NA

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Housewife

16b. Kind of Business/Industry: in home

17. Father's Name (First, Middle, Last): Squire Williams

18. Mother's Name (First, Middle, Maiden Surname): Sina Williams

19a. Informant's Name/Relationship (Type, Print): Sandra Scott

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 5905 St. Regis Road Baltimore, Maryland 21206

20a. Method of Disposition: ☒1 Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Garrison Forst VA Cem. Date: 04-05-01

20c. Location - City or Town, State: Owings Mills MD

21. Signature of Funeral Service Licensee: ▶ Gladys Warner

22. Name and Address of Facility: Baltimore, Maryland 21202 WM.C.March FH 1101 E. North Avenue

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. PNEUMONIA

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. OBSTRUCTIVE SLEEP APNEA

Due to (or as a consequence of):

c. MULTIPLE MYELOMA

Due to (or as a consequence of):

d. RENAL INSUFFICIENCY

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1☐Yes 2☒No 9☐Unknown

23c. If yes, outcome of pregnancy: 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown

23d. Date of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

COR PULMONALE

DIABETES MELLITUS

23e. Did tobacco use contribute to the cause of death? 1☒Yes 2☐No 3☐Probably 4☐Unknown

24a. Was an autopsy performed? 1☐Yes 2☒No

24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☐No

25. Was case referred to medical examiner? 1☐Yes 2☒No

28. Place of Death (Check only one): Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☐Residence 8☐Other (Specify)

27. Manner of Death: 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐Yes 2☐No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification; To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Gerald J.F. Hogan MD, RESIDENT PHYSICIAN

29c. License number: P14692

29d. Date signed (Month, Day, Year): MARCH 30th, 2001

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): GERALD J.F. HOGAN, MD; MERCY MEDICAL CENTER, 301 ST. PAUL PLACE, BALTIMORE, MD

State Registrar

31. Date filed (Month, Day, Year): APR 04 2001

32. Registrar's Signature: Sandra B Sparks

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 | 0309

Physician /Medical Examiner

Funeral Director

1. Decedent's Name (First, Middle, Last): Dallas Roundtree

2. Date of Death: Month APRIL Day 1 Year 2001

3. Time of Death: 1812

4a. Facility Name (If not institution, give street and number): THE JOHNS HOPKINS HOSPITAL

4b. City, Town, or Location of Death: BALTIMORE CITY

4c. County of Death:

5. Social Security Number: 214-56-7480

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 49 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): 10 08 51

9. Birthplace (State or Foreign Country): M.D.

Usual Residence of Decedent

10a. State: MD

10b. County: NA

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1 [X] Yes 2 [ ] No

10e. Street and Number: 1733 North Broadway

10f. Zip Code: 21213

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [ ] Widowed 4 [X] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 10th grade; College (1-4or 5+): na

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Barber

16b. Kind of Business/Industry: Barber Shop

17. Father's Name (First, Middle, Last): Carldon Roundtree

18. Mother's Name (First, Middle, Maiden Surname): Beulah Randolph

19a. Informant's Name/Relationship (Type, Print): Beulah Roundtree-Mother

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3405 Vargas Cir, Baltimore, Md 21244

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): King Memorial Park

Date: 4/5/01

20c. Location - City or Town, State: Randallstown, Md

21. Signature of Funeral Service Licensee: Jerome A. Thompson

22. Name and Address of Facility: March F/H West, 4300 Wabash Ave, Baltimore, Md 21215

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) a.	Intracranial Hemorrhage	24 hours
Due to (or as a consequence of): b.	Hypertension	24 hours
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last: Due to (or as a consequence of): c.		
Due to (or as a consequence of): d.		

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: MD

29c. License number: RES-000

29d. Date signed (Month, Day, Year): April, 1, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Eric Amundson, Johns Hopkins Hospital, Baltimore, Maryland

State Registrar

31. Date filed (Month, Day, Year): APR 04 2001

32. Registrar's Signature: Geneva G Spates

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 10310

AMND ITM# 19a PER F.H. G794 4-4-2001 JAB

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): JAMES A. ROACH

2. Date of Death (Month, Day, Year): 04-01-2001

3. Time of Death: 11:05 AM

4a Facility Name (If not institution, give street and number): MARINER CATONSVILLE NURSING HOME

4b. City, Town, or Location of Death: CATONSVILLE

4c. County of Death: BALTIMORE

Funeral Director

5. Social Security Number: 217-18-1751

6. Sex: 1☑ M 2☐ F

7. Age (In yrs. last birthday): 82 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): 03-14-1918

9. Birthplace (State or Foreign Country): MD

Usual Residence of Decedent

10a. State: MD

10b. County: N/A

10c. City, Town or Location: BALTIMORE

10d. Inside City Limits: 1☑ Yes 2☐ No

10a. Street and Number: 104 ALLENDALE STREET

10f. Zip Code: 21229

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☑ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☑ Yes 2☐ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☑ No Specify:

14. Race - American Indian, Black, White, etc. Specify: BLACK

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12) UK; College (1-4or 5+) UK

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): CUSTODIAN

16b. Kind of Business/Industry: POST OFFICE

17. Father's Name (First, Middle, Last): ~~FRANK ROACH~~ JOYCE A. DORSEY

18. Mother's Name (First, Middle, Maiden Surname): LILLIAN PARROT

19a. Informant's Name/Relationship (Type, Print): FRANK R

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 21 DUNBAR AVENUE, BALTIMORE, MD 21228

20a. Method of Disposition: 1☑ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donetion 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): WOODLAWN CEMETERY

Date: 04.05.01

20c. Location - City or Town, State: BALTO. MD

21. Signature of Funeral Service Licensee: ▶ Vaughn C [illegible]

22. Name and Address of Facility: VAUGHN C. GREENE FUNERAL SERVICE 5151 BALTO. NATL' PIKE, BALTO. MD. 21229

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feilure. List only one ceuse on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Finel disease or condition resulting in death)

a. Aspiration pneumonia — 1 week

Due to (or as a consequence of):

Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initieted events resulting in death) Last

b. cerebrovascular Accident — 1 year.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Hypertension

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☐ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☑ Nursing Home 5☐ Residence 8☐ Other (Specify)

27. Manner of Death: 1☐ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated.

29b. Signature and title of certifier: ▶ Karipinen M.D

29c. License number: D26307

29d. Date signed (Month, Day, Year): 4/3/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): RANI S. KARIPINENI. 4000 ANNAPOLIS RD, BALTIMORE, MD 21227

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State Registrar

31. Date filed (Month, Day, Year): APR 04 2001

32. Registrar's Signature: ▶ Donna G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Amend Item#17,20b,20c perFHG794 4/16/2001 EW

Certificate of Death

Reg. No. 2001 | 10311

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)			2. Date of Death Month / Day / Year	3. Time of Death
Ruth	Lee	Sanders	April 2, 2001	532 am

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Maryland General Hospital	Baltimore City	N/A.

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
249-52-4362	1☐ M 2☒ F	79 Yrs.			12/1/1921	S.C.

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD.	N/A.	BALT.	1☒ Yes 2☐ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
4339 Danlou Dr.	21207	U.S.A

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yas, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐ Nevar Married 2☐ Married 3☒ Widowed 4☐ Divorced	1☐ Yas 2☒ No If Yes, Give Year or Datas:	1☐ Yes 2☒ No Specify:	Specify: Black

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
9th GRADE	N/A.	Nuesing Aid	Hosp. Aid.

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surnama)
~~Ernest Cornell~~ Ernest Cornwell	Eliza Pender Gross

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Dorothea Sanders Hicks	4339 Danlou Dr. Balt. MD. 21207

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)	~~Mt. Olivet Cemc,~~ Voshell Memorial Park	4-6-01	Balto, Md ~~Hyattsville MD.~~

21. Signature of Funeral Service Licansee	22. Name and Address of Facility
Patricia Betts	Betts Funeral Home 1123 N. Caroline St. Balto. Md. 21213

Physician /Medical Examiner

23a. Part1. Enter the diseese, or complicetions that caused the deeth. Do not enter the mode of dying, such as cardiac or raspiratory arrest, shock, or heert failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Finai disease or condition resulting in death)

a. Arteriosclerotic Cerebral Vascular Disease

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting in death) Last

b. Diabetes Mellitus

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other etgnificant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Multiple Decubitus Ulcers, Arteriolar Nephrosclerosis, Electrolyte Imbalance

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☒ Yes 2☐ No	1☒ Yes 2☐ No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐ Yes 2☒ No	Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA	Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Panding investigation 6☐ Could not be determined		M	1☐ Yes 2☐ No	

28a. Place of Injury - At homa, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date end piece, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigetion, in my opinion, death occurred at the time, date and placa, and due to tha cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
Eric Marcalus M.D.	713526	4/2/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Eric Marcalus, M.D. 4339 Maryland General Hospital

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
APR 04 2001	Jennifer Sparks

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Ruth Sanders
Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

2

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 10312

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Agnes Scott

2. Date of Death: Month 4 Day 2 Year 01

3. Time of Death: 8 pm

4a. Facility Name (If not institution, give street and number): Copper Ridge

4b. City, Town, or Location of Death: Sykesville MD

4c. County of Death: Carroll

Funeral Director

5. Social Security Number: 193-09-3721

6. Sex: 1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday): 88 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): DEC 25, 1912

9. Birthplace (State or Foreign Country): PA.

Usual Residence of Decedent

10a. State: MD. | 10b. County: CARROLL | 10c. City, Town or Location: SYKESVILLE | 10d. Inside City Limits: 1 ☒ Yes 2 ☐ No

10e. Street and Number: 710 OBRECHT RD. | 10f. Zip Code: 21784 | 10g. Citizen of What Country? U.S.A.

11. Marital Status: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): HOMEMAKER

16b. Kind of Business/Industry: OWN HOME

17. Father's Name (First, Middle, Last): RALPH BEATTY

18. Mother's Name (First, Middle, Maiden Surname): ALMA COULTER

19a. Informant's Name/Relationship (Type, Print): JANE SCOTT

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 9569 RED APPLE LA. COLUMBIA, MD. 21046

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, cremetory or other place): SPRING CH. LUTH. CEM. | Date: APRIL 6, 2001

20c. Location - City or Town, State: KISKI TOWNSHIP PA.

21. Signature of Funeral Service Licensee: Thomas J. Skarda Jr.

22. Name and Address of Facility: SKARDA F.H. 2829 HUDSON ST. BALTIMORE, MD. 21224

Physician /Medical Examiner

23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Alzheimers Dementia — 13 yrs

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☑ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No

26. Place of Death (Check only one): Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | Other: 4 ☑ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Robert L. Moss, MD

29c. License number: D32882

29d. Date signed (Month, Day, Year): 4/3/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Robert L. Moss, MD 114 Business Center Drive Reisterstown, Md

State Registrar

31. Data filed (Month, Day, Year): APR 04 2001

32. Registrar's Signature: Penelope G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. **To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 10313

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Betty J. Smallwood

2. Date of Death: Month APRIL Day 1 Year 2001

3. Time of Death: 1-55 Am

4a. Facility Name (If not institution, give street and number): NORTH ARUNDEL HOSPITAL

4b. City, Town, or Location of Death: GLEN BURNIE

4c. County of Death: ANNE ARUNDEL

Funeral Director

5. Social Security Number: 219 28 2627

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 68 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): June 26, 1932

9. Birthplace (State or Foreign Country): Pennsylvania

Usual Residence of Decedent

10a. State: Maryland

10b. County: Anne Arundel

10c. City, Town or Location: Glen Burnie

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 1012 Big Baer Drive

10f. Zip Code: 21061

10g. Citizen of What Country?: U.S.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12th | College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker

16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): Charles B. Kelley

18. Mother's Name (First, Middle, Maiden Surname): Irene Palmer

19a. Informant's Neme/Relationship (Type, Print): JoAnn L. Slemp / Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1012 Big Baer Drive Glen Burnie, Maryland 21061

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Meadowridge Mem. Park

Date: 4/4/01

20c. Location - City or Town, State: Baltimore, Maryland

21. Signature of Funeral Service Licensee: Jeanne Frommeyer

22. Neme and Address of Facility: Gonce Funeral Home P.A. 4001 Ritchie Highway Baltimore, Md. 21225

Physician /Medical Examiner

23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on eech line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. SEPTICEMIA

Due to (or as a consequence of): b. CONGESTIVE HEART FAILURE

Sequentially list conditions, if sny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of): c. CORONARY ARTERY DISEASE

Due to (or as a consequenca of): d.

Part II. **Other sfgnlfcant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobecco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

24a. Wes en autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☑ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death (Check only one): Hospital: 1☑ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, offica building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: MD

29c. License number: D45149

29d. Date signed (Month, Day, Year): APRIL 1, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): ONABAJO. 301 HOSPITAL DRIVE GLEN BURNIE MD 21061

State Registrar

31. Date filed (Month, Day, Year): APR 0 4 2001

32. Registrar's Signature: Brenda G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Smallwood, Betty J.

5

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 10314

Smith, Clyde

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month / Day / Year	3. Time of Death
Clyde D. Smith	MAR 31 2001	0750AM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Genesis Eldercare Caton Manor	Baltimore	N/A

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
219 22 3259	1☒M 2☐F	72 Yrs.			April 18, 1928	Kentucky

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Howard	Elkridge	1☐Yes 2☒No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
5794 Paradise Avenue	21075	U.S.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☒Never Married 2☐Married 3☐Widowed 4☐Divorced	1☐Yes 2☒No If Yes, Give Year or Dates:	1☐Yes 2☒No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12th		Carpenter	Henry Knott

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Enoch Smith	Jane Hubbard

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Vernice Gray / Sister	5794 Paradise Avenue Elkridge, Maryland 21075

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify) ~	Glen Haven Memorial Park	4/4/01	Glen Burnie, Maryland

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ Jerome Gronouski	Gonce Funeral Home P.A. 4001 Ritchie Highway Baltimore, Md. 21225

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or haart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Sepsis	7 Days
Due to (or as a consequence of):	b. Pneumonia	7 Days
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c.	
Due to (or as a consequence of):	d.	

Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I.

Anemia

23b. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☒Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐Yes 2☒No	1☐Yes 2☐No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)
1☐Yes 2☒No	Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☒Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined		M	1☐Yes 2☐No	
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1☒Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and mannar as stated. 2☐Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ Sanjay P. Shah, MD	D0052940	APR 02 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Sanjay P. Shah, MD 821 N. Eutaw St #407, Baltimore MD21201

State Registrar

31. Data filed (Month, Day, Year)	32. Registrar's Signature
APR 04 2001	▶ Denise G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Amend Item#8 perFHG794 4/9/01 EW

Certificate of Death

Reg. No. 2001 10315

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Hilda Sprenkle

2. Date of Death: Month 4 Day 3 Year 01

3. Time of Death: 0818

4a. Facility Name (If not institution, give street and number): Good Samaritan Hospital

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: N/A

Funeral Director

5. Social Security Number: 218-22-5808

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 88 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): ~~March 27, 1913~~ 3-20-13

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: MD

10b. County: N/A

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1☒ Yes 2☐ No

10a. Street and Number: 5716 Newholme Avenue

10f. Zip Code: 21206

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker

16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): Joseph Bengermino

18. Mother's Name (First, Middle, Maiden Surname): Rose Unknown

19a. Informant's Neme/Relationship (Type, Print): Marshall O. Sprenkle- Husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 5716 Newholme Avenue Baltimore, Maryland 21206

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Gardens of Faith Cem.

Date: 4/6/01

20c. Location - City or Town, State: Baltimore, Maryland

21. Signature of Funeral Service Licensee: Heather Cain

Heather Cain

22. Name and Address of Facility: Leonard J.Ruck, Inc. 5305 Harford Road Baltimore, Maryland 21214

Physician /Medical Examiner

23a. Part1. Enter the disease, or compticelions that caused the deeth. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Deeth

Immediate Cause (Final disease or condition resulting in death)

a. Atherosclerotic Cardiovascular Disease 2yrs

Due to (or es a consequence of):

b. Probable Myocardial Infarction

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Due to (or es a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Diabetes Mellitus

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☒ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated. 2☐ **Medical Examiner:** On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, dete end place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: S Mmm

29c. License number: D30641

29d. Date signed (Month, Day, Year): April 3 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Ramesh Sabapathi 6400 Eastman Ave Baltimore MD 21224

State Registrar

31. Date filed (Month, Day, Year): APR 04 2001

32. Registrar's Signature

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 10316

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Virginia Watts Emory

2. Date of Death (Month, Day, Year): March 31 2001

3. Time of Death: 3:30 AM

4a. Facility Name (If not institution, give street and number): 703 Fern Hill Road

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: Anne Arundel

Funeral Director

5. Social Security Number: 229-24-2477

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 73 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): April 9 1927

9. Birthplace (State or Foreign Country): West Virginia

Usual Residence of Decedent

10a. State: Maryland

10b. County: Anne Arundel

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 703 Fern Hill Road

10f. Zip Code: 21226

10g. Citizen of What Country? USA

11. Meritel Status: 1☐ Never Married 2☐ Merried 3☒ Widowed 4☐ Divorced

12. Wes Decedent Ever in U,S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yeer or Detes:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Rece - American Indien, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementery/Secondery (0-12): 9

College (1-4or 5+):

16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired): Seamstress

16b. Kind of Business/Industry: Clothing

17. Father's Name (First, Middle, Last): Wirt Clark

18. Mother's Neme (First, Middle, Maiden Sumame): Pearl Thorne

19a. Informent'e Neme/Reletionship (Type, Print): Mitch Ross (son)

19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code): 705 Fern Hill Road, Baltimore, MD. 21226

20a. Method of Disposition: 1☒ Burial 2☐ Cremetion 3☐ Removel from Stete 4☐ Donetion 5☐ Other (Specify)

20b. Ptece of Disposition (Neme of cemetery, cremetory or other piece): Glen Haven Cemetery

Date: April 5 2001

20c. Location - City or Town, Stete: Glen Burnie, Maryland

21. Signature of Funeral Service Licensee: Mitchell Stallings

22. Name end Address of Fecility: Stallings Funeral Home, P.A. 3111 Mountain Road, Pasadena, MD. 21122

Physician /Medical Examiner

23a. Part1. Enter the diseese, or complications that caused the death. Do not enter the mode of dying, such es cardiec or respiretory errest, shock, or heert feilure. List only one cause on each line.

Approximete Interval Between Onset and Death

Immedlete Ceuse (Finel diseese or condition resulting in deeth):
e. Non Small cell Lung Cancer — 3 months

Due to (or es e consequence of):
Metastatic To Liver

Sequentially list conditions, if any, leading to immedlete cause. Enter Underlying Cause (Diseese or Injury that initieted events resulting in death) Last

b. Due to (or es a consequence of):

c. Due to (or as a consequence of):

d.

Pert tt. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part i.

23b. Did tobacco use contribute to the cause of death? 1☒ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Wes en eutopsy performed? 1☐ Yes 2☒ No

24b. Were eutopsy findings available prior to completion of cause of deeth? 1☐ Yes 2☐ No

25. Wes case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one)
Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA
Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined

28a. Dete of Injury (Month, Dey Year)

28b. Time of injury M

28c. Injury at Work? 1☐ Yes 2☒ No

28d. Describe how injury occurred

28e. Ptece of Injury - At home, ferm, street, fectory, office building, etc. (Specify)

28f. Location (Street and Number or Rurel Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1☐ **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, date and place, end due to the cause(s) and menner as stated. 2☐ **Medical Examiner:** On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date and ptece, and due to the cause(s) and menner stated.

29b. Signature and title of certifier: Mayer Gorbatz MD

29c. License number: 027938

29d. Date signed (Month, Day, Year): Apr. 12, 2001

30. Neme and address of person who completed cause of death (Item 23a) (Type, Print): Mayer Gorbatz MD 95 Aquahart Rd. Glen Burnie MD 21061

State Registrar

31. Date filed (Month, Day, Year): APR 04 2001

32. Registrar's Signature: Peggy Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

3

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 10317

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)		2. Date of Death Month / Day / Year	3. Time of Death
VIRGINIA	STANCIL	APRIL 01 2001	5:25 P

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Bon Secours Hospital	Baltimore	N/A

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
213-30-2214	1☐ M 2☒ F	66 Yrs.			Jan. 27, 1935	Maryland

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	N/A	Baltimore	1☒ Yes 2☐ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
740 Poplar Grove St. Apt. 11R	21216	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced	1☐ Yes 2☒ No If Yes, Give Year or Dates:	1☐ Yes 2☒ No Specify:	Specify: Black

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12	0	Seamstress	Private Industry

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Daniel Lewis	Fannie Dixon

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Ms. Acquanetta Lampkin (daughter)	4428 Caldwell Square Belcamp, Md. 21017

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)	Balto. National	4/6/2001	Balto. Md.

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
Joseph L. Russ	Joseph L. Russ Funeral Home 2222 W. North Ave Balto. Md. 21216

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. SEPSIS	2 DAYS
Due to (or as a consequence of):		
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. END STAGE CHRONIC OBSTRUCTIVE LUNG DISEASE UNKNOWN	
Due to (or as a consequence of):		
	c.	
Due to (or as a consequence of):		
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

HYPERTENTION

DIABETES MELLITUS

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐ Yes 2☒ No	1☐ Yes 2☐ No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐ Yes 2☒ No	Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA	Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined		M	1☐ Yes 2☐ No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
MD.	D. 23300	APRIL 01 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
SUDHIR PATEL 2900 W. BALTIMORE ST. BALTO - 21223 BON SECOURS HOSP.

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
APR 04 2001	

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 10318

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
ELIZABETH ANN MUNDEW SNOW	March 31, 2001	10:28 AM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
408 Hopkins Road	Rodgers Forge	Baltimore County

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
292-16-4305	1☐M 2☒F	82 Yrs.			Feb 27, 1919	Ohio

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Baltimore County	Rodgers Forge	1☐Yes 2☒No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
408 Hopkins Road	21212	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐Never Married 2☒Married 3☐Widowed 4☐Divorced	1☒Yes 2☐No If Yes, Give Year or Dates: WW2	1☐Yes 2☒No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
	1 yr	Co-owner	Insurance agency

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Ezra Mundew	Lou Edna Andrew

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
James Jonathan Snow (Son)	408 Hopkins Road, Baltimore, Maryland 21212

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☐Burial 2☒Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	Green Mount Crematory	4/3/2001	Baltimore, Maryland

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
Martin D. Lawson	Mitchell-Wiedefeld Funeral Home, Inc. 6500 York Road, Baltimore, Maryland 21212

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Acute MI	Minutes
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	b. Due to (or as a consequence of): CAD	>24 yrs
	c. Due to (or as a consequence of):	
	d. Due to (or as a consequence of):	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month Day Year
1☐Yes 2☐No 9☐Unknown	1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?	24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐Yes 2☒No 3☐Probably 4☐Unknown	1☐Yes 2☒No	1☐Yes 2☐No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐Yes 2☒No	Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA	Other: 4☐Nursing Home 5☒Residence 6☐Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☐Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined		M	1☐Yes 2☐No	
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one)
1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and Title of Certifier	29c. License number	29d. Date signed (Month, Day, Year)
MD	D22789	April 2, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Stuart B. Bell, M.D., 200 E. 33rd Street, Baltimore, Maryland 21218

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
APR 04 2001	Denise D. Sparks

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23e or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

DHMH 17 Rev 1/2001

ORIGINAL

Thomas

Patient known as Annette

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 10319

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Annette Thomas
2. Date of Death (Month, Day, Year): March 28, 2001
3. Time of Death: 9:07 a.m.
4a. Facility Name (If not institution, give street and number): Sinai Hospital of Baltimore
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 259-52-8081
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 64 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): March 30, 1936
9. Birthplace (State or Foreign Country): Georgia

Usual Residence of Decedent

10a. State: Maryland
10b. County: N/A
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 3800 W. Belvedere Ave. #227
10f. Zip Code: 21215
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: African American

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 9 | College (1-4or 5+): 0
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker
16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): James McCoy
18. Mother's Name (First, Middle, Maiden Surname): Carrie Mae Thomas

19a. Informant's Name/Relationship (Type, Print): Mr. Solomon Thomas (Husband)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3800 W. Belvedere Ave. #227 Balto. Md. 21215

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Greenmount Crematory
Date: 4/4/2001
20c. Location - City or Town, State: Balto. Md.

21. Signature of Funeral Service Licensee: Joseph L. Russ
22. Name and Address of Facility: Joseph L. Russ Funeral Home 2222 W. North Ave. Balto. Md. 21216

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death):
a. Sepsis
Due to (or as a consequence of):
b. Lactic Acidosis

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c. Multisystem Organ Failure
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☒ Yes 2☐ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residance 6☐ Other (Specify)
27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day, Year)
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Christopher Davis
29c. License number: D55609
29d. Date signed (Month, Day, Year): April 3, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Christopher Davis, MD, 2401 West Belvedere Ave, Baltimore, MD 21215

State Registrar

31. Date filed (Month, Day, Year): APR 04 2001
32. Registrar's Signature: Donna G Sparks

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 10320

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): EVELYN THOMAS
2. Date of Death: Month MARCH Day 28 Year 2001
3. Time of Death: 12:17 PM
4a. Facility Name (If not institution, give street and number): NORTHWEST HOSPITAL CENTER
4b. City, Town, or Location of Death: RANDALLSTOWN
4c. County of Death: BALTIMORE

Funeral Director

5. Social Security Number: 218-10-0347
6. Sex: 1☐ M 2☑ F
7. Age (In yrs. last birthday): 88 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 06-26-1912
9. Birthplace (State or Foreign Country): MD

Usual Residence of Decedent

10a. State: MD
10b. County: BALTIMORE
10c. City, Town or Location: GWYNN OAK
10d. Inside City Limits: 1☐ Yes 2☑ No
10e. Street and Number: 1817 COLMAR ROAD
10f. Zip Code: 21207
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☑ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☑ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☑ No Specify:
14. Race - American Indian, Black, White, etc. Specify: BLACK

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12TH GRADE; College (1-4or 5+): N/A
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): CAFETERIA WORKER
16b. Kind of Business/Industry: BALTO. CITY SCHOOLS

17. Father's Name (First, Middle, Last): GEORGE GENT
18. Mother's Name (First, Middle, Maiden Surname): VIOLA ADDISON

19a. Informant's Name/Relationship (Type, Print): MICHELLE THOMAS | DAUGHTER
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1817 COLMAR RD., BALTO. MD. 21207

20a. Method of Disposition: 1☐ Burial 2☑ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): METRO CREMATORY
Date: 04.02.01
20c. Location - City or Town, State: BALTO. MD

21. Signature of Funeral Service Licensee: ▶ Vaughn C [illegible]
22. Name and Address of Facility: CREMATION SERVICES, 5151 BALTO. NATL. PIKE, BALTO. MD. 21229

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. ACUTE MYOCARDIAL INFARCTION — 1 HOUR

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

SEIZURE DISORDER

BREAST CANCER

CEREBROVASCULAR ACCIDENT

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☐ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☐ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day, Year)
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ [signature] MD
29c. License number: 047587
29d. Date signed (Month, Day, Year): MARCH 28, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): ROBERT FINE, MD 5701 OLD COUNT ROAD, RANDALLSTOWN, MD 21133

State Registrar

31. Date filed (Month, Day, Year): APR 04 2001
32. Registrar's Signature: ▶ Geneva G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 10321

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Mary Belle Winslow
2. Date of Death: Month 4 Day 2 Year 2001
3. Time of Death: 0300A
4a. Facility Name (If not institution, give street and number): Noble House Nursing Home
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: NA

Funeral Director

5. Social Security Number: 246-46-2663
6. Sex: 1☐M 2☐F X
7. Age (In yrs. last birthday): 70 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 06-16-30
9. Birthplace (State or Foreign Country): NC

Usual Residence of Decedent

10a. State: MD
10b. County: NA
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1☐Yes 2☐No XX
10e. Street and Number: 513 N. Decker Avenue
10f. Zip Code: 21205
10g. Citizen of What Country: USA

11. Marital Status: 1☐Never Married 2☐Married X☒Widowed 4☐Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐Yes 2☒No X If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☐No X Specify:
14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12th Grade; College (1-4or 5+): NA
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Food Service Dietian
16b. Kind of Business/Industry: City Hospital

17. Father's Name (First, Middle, Last): Lemuel Boone
18. Mother's Name (First, Middle, Maiden Surname): Gussie Morgan

19a. Informant's Name/Relationship (Type, Print): Willie Boone
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 513 N. Decker Avenue Baltimore, Maryland 21205

20a. Method of Disposition: 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)
20b. Place of Disposition (Name of cemetery, cremetory or other place): Mt. Zion Cemetery
Date: 04-06-01
20c. Location - City or Town, State: Lansdowne, MD

21. Signature of Funeral Service Licensee: ▶ Gladys Warner
22. Name and Address of Facility: Baltimore, Maryland 21202 WM.C.March FH 1101 E. North Avenue

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) a.	Congestive Heart Failure	3 days
Due to (or as a consequence of): b.	Renal Failure	1 month
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last. Due to (or as a consequence of): c.	Diabetes Mellitus	15 years
d.		

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Peripheral vascular disease

23b. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☒Unknown

24a. Was an autopsy performed? 1☐Yes 2☒No
24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☐No

25. Was case referred to medical examiner? 1☐Yes 2☒No

26. Place of Death (Check only one): Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☑Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death: 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐Yes 2☐No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ MD
29c. License number: D38675
29d. Date signed (Month, Day, Year): 4/2/01

30. Name and address of person who completed cause of death (item 23a) (Type, Print): JOEL MESHULAM 301 ST PAUL PL SUITE 605 BALTIMORE MD 21202

State Registrar

31. Date filed (Month, Day, Year): APR 04 2001
32. Registrar's Signature: Bernice B Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Baltimore, Maryland 21215-0020

MARY WINSLOW

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 10322

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): HARRY WILLIAMS

2. Date of Death: Month MARCH Day 28 Year 2001

3. Time of Death: 10:40 AM

4a. Facility Name (If not institution, give street and number): NORTHWEST HOSPITAL CENTER

4b. City, Town, or Location of Death: RANDALLSTOWN

4c. County of Death: BALTIMORE

Funeral Director

5. Social Security Number: 213-16-9563

6. Sex: 1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday): 78 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): 09 21 22

9. Birthplace (State or Foreign Country): M.D.

Usual Residence of Decedent

10a. State: MD

10b. County: NA

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1 ☒ Yes 2 ☐ No

10e. Street and Number: 2510 Hallam Ct.

10f. Zip Code: 21244

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 ☒ Yes 2 ☐ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 6th grade

College (1-4or 5+): na

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Stock Clerk

16b. Kind of Business/Industry: Hess Shoe Dept.

17. Father's Name (First, Middle, Last): George Williams

18. Mother's Name (First, Middle, Meiden Surname): Rachelle Adams

19a. Informant's Neme/Reletionship (Type, Print): Latoria Green-Grand-Daughter

19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2510 Hallam Ct, Baltimore, Md 21244

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Garrison Forest Vet.

Date: 4/5/01

20c. Location - City or Town, State: Owings Mills, Md

21. Signature of Funeral Service Licensee: Herme A. Thompson

22. Name and Address of Facility: March F/H West, 4300 Wabash Ave, Baltimore, Md 21215

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications thet caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in deeth)

a. ACUTE MYOCARDIAL INFARCTION — 1 HOUR

Due to (or es a consequence ot):

b. HYPERTENSIVE CARDIOVASCULAR DISEASE — YEARS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initieted events resulting in death) Last

Due to (or es a consequenca ot):

c.

Due to (or es a consequence of):

d.

Part II. **Other signifIcant conditIons** contributing to death but not resulting in the underlying cause given in Part I.

PRIOR CEREBROVASCULAR ACCIDENT

NON-INSULIN DEPENDENT DIABETES MELLITUS

23b. Did tobacco use contributa to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Wes en eutopsy performed? 1 ☐ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No

26. Piece of Death (Check only one)

Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ☐ Natural 2 ☑ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Piece of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☐ **Certifying Physician:** To the best of my knowledge, deeth occurred at the time, dete end plece, end due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) and menner steted.

29b. Signature and title of certifier: MD

29c. License number: 047587

29d. Date signed (Month, Day, Year): MARCH 28, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): ROBERT FINE MD 5401 OLD COURT ROAD, RANDALLSTOWN, MD 21133

State Registrar

31. Dete filed (Month, Day, Year): APR 04 2001

32. Registrar's Signature: Geneva G Sparks

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Amend Item#16b perFHG794 4/4/01 EW

Certificate of Death

Reg. No. 2001 10323

Gertrude Ward
Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Gertrude E. Ward
2. Date of Death: Month March Day 29, Year 2001
3. Time of Death: 4:27 am
4a. Facility Name (If not institution, give street and number): Maryland General Hospital
4b. City, Town, or Location of Death: Baltimore City
4c. County of Death:

Funeral Director

5. Social Security Number: 212-26-9676
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 72 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 01 08 29
9. Birthplace (State or Foreign Country): V.A.

Usual Residence of Decedent

10a. State: MD
10b. County: NA
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 1937 Clifton Ave
10f. Zip Code: 21217
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12th grade; College (1-4or 5+): na
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Nurse
16b. Kind of Business/Industry: Health Care Provider ~~Provide~~

17. Father's Name (First, Middle, Last): Joseph F. Roland
18. Mother's Name (First, Middle, Maiden Surname): Charlesanna

19a. Informant's Name/Reletionship (Type, Print): McConnell P. Roland-Son
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2106 Fern Glen Way, Catonsville Md 21228

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): King Memorial Park Date: 4/4/01
20c. Location - City or Town, State: Randallstown, Md

21. Signature of Funeral Service Licensee: Lola March
22. Name and Address of Facility: March F/H West 4300 Wabash Ave, Baltimore Md 21215

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. (Approximate Interval Between Onset and Death)

Immediate Cause (Final disease or condition resulting in death):
a. Arrhythmia
Due to (or as a consequence of):
b. Pneumonia

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No
26. Place of Death (Check only one): Hospital: 1☑ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)
27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

29a. Certifier (Check only one): 1☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier:
29c. License number: P 13526
29d. Date signed (Month, Day, Year): 3/29/01
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Eric Marcalus, M.D. c/o Maryland General Hospital

State Registrar

31. Date filed (Month, Day, Year): APR 04 2001
32. Registrar's Signature: Geneva G Sparks

DHMH 16 Rev 6/95

ORIGINAL

01-1678-510
CJ
John White

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar UNPENDED 073001: ITEMS#23a,27,28a-f per ME 6797 SS

Certificate of Death

Reg. No. 2001 10324

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month / Day / Year	3. Time of Death
John J. White	March 26 2001	10:04 A.M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Mercy Hospital	Baltimore	N/A

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
226-60-0204	1☐M 2☐F XX	56 Yrs.			03-22-45	NC

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	NA	Baltimore	1☒Yes 2☐No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
1712 Guilford Avenue	21218	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐Never Married 2☒Married XX 3☐Widowed 4☐Divorced	1☐Yes 2☒No XX If Yes, Give Year or Dates:	1☐Yes 2☐No XX Specify:	Specify: Black

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	18b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
High Sch.	NA	Disabled	Disabled

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
William White	Holly Hill

19a. Informent's Neme/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21202
Jerome Whitherspoon	1708 Guilford Avenue Baltimore, Maryland

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	Voshell Mem. Gardens	04-05-01	Dundalk, MD

21. Signature of Funeral Servica Licensee	22. Name and Address of Facility
▶ Gladys Warner	Baltimore, Maryland 21202 WM.C.March FH 1101 E. North Avenue

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

23a. Part I. Enter the disease, or complicetions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line.

Approximate Intervel Between Onset and Death

Immediate Cause (Final diseese or condition resulting in deeth)

a. LONG TERM COMPLICATIONS OF REMOTE GUNSHOT WOUND

Due to (or as a consequenca of):

Sequenttally list conditions, if any, teeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. _____

Due to (or es a consequenca of):

c. _____

Due to (or as a consequence of):

d. _____

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month / Dey / Year
1☐Yes 2☒No 9☐Unknown	1☐Live birth 2☐Fetel death 3☐Ectopic pregnency 4☐Pregnent at time of death 5☐Other (specify) _____ 9☐Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☒Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☒Yes 2☐No	1☒Yes 2☐No

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

25. Was case referred to medical exeminer?	26. Place of Death (Check only one) Hospital:	Other:
XX1☒Yes 2☐No	1☐Inpatient 2☒ER/Outpatient 3☐DOA	4☐Nursing Home 5☐Residenca 6☐Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Yeer)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☐Natural 2☐Accident 3☒Suicide 4☐Homicide 5☐Pending investigetion 6☐Could not be determined	unknown	unknown M	1☐Yes 2☒No	subject shot self

28e. Place of Injury - At home, farm, street, factory, offica building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)
unknown	unknown

29a. Certifier (Check only one)
1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as steted.
2☒ **Medical Examinar:** On the basis of examination and/or investigation, in my opinion, death occurred at tha time, date and piece, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ Dennis J. Cluteau	O.C.M.E.	March 27, 2001

30. Neme end address of person who completed cause of death (Item 23a) (Type, Print)
Dennis Chute MD 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
APR 04 2001	▶ L. Sparks

DHMH 17 Rev 1/2001

ORIGINAL

CPS
01-1187-510
ROBERT WATERS

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar AMEND ITEM 23a,27,28a-f perME G794 040601 SS

Certificate of Death

Reg. No. 2001 10325

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)			2. Date of Death Month Day Year	3. Time of Death
Robert	J.	Waters	March 2, 2001	20:47 PM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
1815 McHenry Street	Baltimore	

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
220-64-3906	XX 1 M 2 F	45 Yrs.			01 11 56	G. A.

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	NA	Baltimore	1 X Yes 2 No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
619 McKewin Ave	21228	U.S.A.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1 X Never Married 2 Married 3 Widowed 4 Divorced	1 Yes 2 X No If Yes, Give Year or Dates:	1 Yes 2 XX No Specify:	Specify: Black

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	18b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
10th grade	na	ConstructionnWorker	Construction Co.

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Robert Lee Waters	Delores Dixon

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Delores Waters-Mother	2802 Clayton Drive, Valdosta, G.A. 31602

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1 XX Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)	Mt. Zion Cemetery	4/4/01	Baltimore, Md

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ [signature]	March F/H West 4300 Wabash Ave, Baltimore, Md 21215

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. NARCOTIC AND COCAINE INTOXICATION	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of): b.	
	Due to (or as a consequence of): c.	
	Due to (or as a consequence of): d.	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month Day Year
1 Yes 2 No 9 Unknown	1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify) 9 Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the causa of death?	24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1 Yes 2 ✓ No 3 Probably 4 Unknown	1 ✓ Yes 2 No	1 Yes 2 No

Medical Certification; To Be Completed by Physician/Medical Examiner

25. Was case referred to medical examiner?	28. Place of Death (Check only one)	
1 X Yes 2 No	Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA	Other: 4 Nursing Home 5 Residence 6 X Other (Specify) SCENE

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1 Natural 2 Accident 3 Suicide 4 Homicide 5 ~~Pending investigation~~ 6 X Could not be determined	found: 3-2-01	found: 8:35 PM	1 Yes 2 X No	unknown

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)
other residence	1815 McHENRY ST., Balto., MD

29a. Certifier (Check only one)
1 **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 X **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ [signature]	OCME	March 3, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
MARYANNE B. KNOX 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
APR 04 2001	▶ [signature]

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 10326

Physician /Medical Examiner

1. Decedent's Neme *(First, Middle, Last)*: DURBROW H. WALLACE

2. Dete of Death — Month: MARCH Day: 29 Year: 2001

3. Time of Deeth: 1346

4e. Facility Name *(If not institution, give street end number)*: PENINSULA REGIONAL MEDICAL CENTER

4b. City, Town, or Location of Death: SALISBURY

4c. County of Death: WICOMICO

Funeral Director

5. Social Security Number: 098-05-0576

6. Sex: 1☒ M 2☐ F

7. Age *(In yrs. last birthdey)*: 87 Yrs. — If Under 1 Year: Months / Deys — If Under 24 Hrs.: Hours / Min.

8. Dete of Birth *(Month, Dey, Year)*: Apr 27, 1913

9. Birthplace *(Stete or Foreign Country)*: New York

Usuel Residence of Decedent

10a. Stete: MD

10b. County: WICOMICO

10c. City, Town or Location: SALISBURY

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 27809 Riverside Drive

10f. Zip Code: 21801

10g. Citizen of What Country?: USA

11. Meritel Stetus: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Wes Decedent Ever in U.S. Armed Forces? 1☒ Yes 2☐ No — If Yes, Give Yeer or Detes: WWII

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No *Specify*: X

14. Rece - American Indien, Bleck, White, etc. *Specify*: white

15. Decedent's Education *(Specify only highest grade completed)*: Elementery/Secondery (0-12): 12 — College (1-4or 5+):

16a. Decedent's Usuel Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: mechanic

16b. Kind of Business/Industry: Proctor & Gamble

17. Father's Neme *(First, Middle, Last)*: William Wallace

18. Mother's Neme *(First, Middle, Maiden Surneme)*: Mary Louise Grann

19e. Informent's Neme/Reletionship *(Type, Print)*: William Wallace/son

19b. Meiling Address *(Street and Number or Rural Route Number, City or Town, Stete, Zip Code)*: 27809 Riverside Drive Salisbury, MD 21801

20e. Method of Disposition: 1☐ Buriel 2☐ Cremetion 3☐ Removel from Stete 4☒ Donetion 5☐ Other *(Specify)*

20b. Piece of Disposition *(Neme of cemetery, cremetory or other piece)*:

Dete:

20c. Location - City or Town, Stete:

21. Signature of Funerel Service Licensee: Ronald S. Wade, Director

22. Neme end Address of Fecility: State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201

Physician /Medical Examiner

23a. Pert I. Enter the disease, or complications thet caused the deeth. Do not enter the mode of dying, such es cardiec or respiretory errest, shock, or heert feilure. List only one cause on eech line.

Approximete Interval Between Onset and Deeth

Immediate Cause (Finel diseese or condition resulting in death)
a. Hemorrhagic Cerebrovascular Accident — 48hrs
Due to (or es a consequenca of):

Sequentially list conditions, if eny, leeding to immediete cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last
b.
Due to (or es a consequenca of):
c.
Due to (or as a consequence of):
d.

Pert II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Pert I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24e. Wes an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Wes case referred to medical exeminer? 1☐ Yes 2☒ No

26. Piece of Deeth *(Check only one)*: Hospitel: 1☒ Inpetient 2☐ ER/Outpetient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 6☐ Othar *(Specify)*

27. Menner of Deeth: 1☒ Neturel 2☐ Accident 3☐ Sulcide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined

28e. Dete of Injury *(Month, Dey Year)*:

28b. Time of Injury:

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred:

28e. Piece of Injury - At home, ferm, street, fectory, office building, etc. *(Specify)*:

28f. Location *(Street and Number or Rurel Route Number, City or Town, Stete)*:

29e. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, deeth occurred at the time, dete and piece, end due to the cause(s) and menner es stated. 2☐ **Medical Examiner:** On the basis of examinetion end/or investigetion, in my opinion, death occurred at the time, date end place, and due to the cause(s) end menner steted.

29b. Signeture and title of certifier: Robert A. Coker D - Physician

29c. License number: H0015647

29d. Date signed *(Month, Day, Year)*: 3/29/01

30. Neme end address of person who completed cause of deeth (Item 23a) (Type, Print): Robert A. Coker D Peninsula Regional Medical Center Salisbury MD 21801

State Registrar

31. Dete filed *(Month, Day, Year)*: APR 0 4 2001

32. Registrer's Signeture: Geneva G Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

BURBROW WALLACE

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 10327

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Monford Wolf
2. Date of Death: Month April Day 1, Year 2001
3. Time of Death: Between 0200-0500
4a. Facility Name (If not institution, give street and number): 732 S. Conkling Street
4b. City, Town, or Location of Death: Baltimore City
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 212-30-4467
6. Sex: 1 ☒ M 2 ☐ F
7. Age (In yrs. last birthday): 70 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Feb. 13, 1931
9. Birthplace (State or Foreign Country): Md.

Usual Residence of Decedent

10a. State: Md.
10b. County: N/A
10c. City, Town or Location: Baltimore City
10d. Inside City Limits: 1 ☒ Yes 2 ☐ No
10e. Street and Number: 732 S. Conkling Street
10f. Zip Code: 21224
10g. Citizen of What Country?: USA

11. Marital Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☒ Yes 2 ☐ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12): 12 yrs.
College (1-4or 5+): 4 yrs.
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Pension Specialist
16b. Kind of Business/Industry: Internal Revenue Servic

17. Father's Name (First, Middle, Last): William Wolf
18. Mother's Name (First, Middle, Maiden Surname): Ida Conn

19a. Informant's Name/Relationship (Type, Print): Mary Wolf wife
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 732 S. Conkling St. Baltimore, Md. 21224

20a. Method of Disposition: 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Bayview Crematory
Date: April 2 2001
20c. Location - City or Town, State: Baltimore City, Md.

21. Signature of Funeral Service Licensee: John E. Connelly
22. Name and Address of Facility: Connelly Funeral Home of Dundalk, P.A. 7110 Sollers POint Road. Dundalk, Md. 21222

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Cardio respiratory arrest
Due to (or as a consequence of):
b. Malignant Left Pleural Effusion
Due to (or as a consequence of):
c. Metastatic pancreatic Cancer
Due to (or as a consequence of):
d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. **Did tobacco use contribute to the cause of death?** 1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No
26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)
27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: Stephen Hall M
29c. License number: D22034
29d. Date signed (Month, Day, Year): 4-3-01
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): MORGAN, BURTON 412, 5601 LOCH RAVEN BLVD., BALT. 21239

State Registrar

31. Date filed (Month, Day, Year): APR 04 2001
32. Registrar's Signature: Jennie D Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important:** If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit copy.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 10328

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): EDITH L. YOUNG
2. Date of Death (Month, Day, Year): MARCH 28, 2001
3. Time of Death: 7:50 PM
4a. Facility Name (If not institution, give street and number): National Lutheran Home
4b. City, Town, or Location of Death: Rockville
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 138-34-8689
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 91 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Aug 11, 1909
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: MD
10b. County: Montgomery
10c. City, Town or Location: Rockville
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 9701 Veirs Drive
10f. Zip Code: 20850
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: white

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+): 0
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): homemaker
16b. Kind of Business/Industry: none

17. Father's Name (First, Middle, Last): Luther E. Mackey
18. Mother's Name (First, Middle, Maiden Surname): Katherine Hartan

19a. Informant's Name/Relationship (Type, Print): David Young/son
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4160 Vista Drive martinsburg, WV 25401

20a. Method of Disposition: 1☐ Burial 2☐ Cremation 3☐ Removal from State 4☒ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place):
Date:
20c. Location - City or Town, State:

21. Signature of Funeral Service Licensee: Ronald S. Wade, Director
22. Name and Address of Facility: State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) a.	Acute cerebrovascular Accident	2 days
Due to (or as a consequence of): b.	Pneumonia	2 days
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last. Due to (or as a consequence of): c.	atrial fibrillation	years
d.		

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Chronic obstructive pulmonary disease

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☑ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Charles W. Kenerly MD
29c. License number: D21726
29d. Date signed (Month, Day, Year): March 29, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): CHARLES KARESH NATIONAL LUTHERAN HOME

State Registrar

31. Date filed (Month, Day, Year): APR 0 4 2001
32. Registrar's Signature: Geneva G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 10329

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Lester W Boyer
2. Date of Death (Month, Day, Year): March 18, 2001
3. Time of Death: 6;45 PM
4a. Facility Name (If not institution, give street and number): 8438 Edgewood Church Road
4b. City, Town, or Location of Death: Frederick
4c. County of Death: Frederick

Funeral Director

5. Social Security Number: 214-14-6395
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 79 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): December 11, 1921
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Frederick
10c. City, Town or Location: Frederick
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 8438 Edgewood Church Road
10f. Zip Code: 21702
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: 1942-1945
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yas, specify Cuban, Maxicen, Puerto Rican, atc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Bleck, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12) / College (1-4 or 5+): 4
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Research Agronomist
16b. Kind of Business/Industry: Fort Detrick /U.S. Army

17. Father's Name (First, Middle, Last): Lester Walter Boyer
18. Mother's Neme (First, Middle, Maiden Surname): Rebecca Delauter Boyer

19a. Informent's Name/Reletionship (Type, Print): Ann Marie/Wife
19b. Melling Address (Street and Number or Rural Route Number, City or Town, Stata, Zip Code): 8438 Edgewood Church Road, Frederick, Maryland, 21702

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremetion 3 [ ] Removal from State 4 [ ] Donetion 5 [ ] Other (Specify)
20b. Pleca of Disposition (Name of cemetery, crematory or othar place): Mt. Olivet Cemetery
Date: 3/22/01
20c. Location - City or Town, State: Frederick, Maryland

21. Signeture of Funeral Service Licensee: P. Ryan McMillian
22. Nema end Addresa of Facility: Keeney and Basford PA Funeral Home 106 East Church St., Frederick, Md. 21701

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications thet caused the death. Do not enter the mode of dying, such es cardiec or respiratory arrest, shock, or heart failure. List only one ceuse on eech line.

Approximata Interval Betwaen Onset and Deeth

Immediete Ceuse (Finel disease or condition resulting in death): e. Parkinson's Disease — 10 years

Due to (or es a consequence ot):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted eventa resulting in death) Last

b. Due to (or es a consequenca of):

c. Due to (or es a consequence ot):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Part I.

Atrial Fibrillation

Type 2 Diabetes

Hypertension

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yea 2 [X] No

24b. Were autopsy findings eveilable prior to completion of cause of deeth? 1 [ ] Yes 2 [ ] No

25. Wes case referred to medicat examiner? 1 [ ] Yes 2 [X] No

26. Place of Deeth (Check only one): Hospitel: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; Other: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Neturel 2 [ ] Accident 3 [ ] Sulcide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Dete of Injury (Month, Dey Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Pleca of Injury - At home, ferm, atreet, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, deeth occurred at the tima, dete end pleca, end due to the cause(s) and mannar as stated. 2 [ ] **Medical Examiner:** On tha basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, date end piece, end due to the cause(s) end manner steted.

29b. Signetura and title of certifier: Ali Afrookteh MD
29c. License number: D35183
29d. Data signed (Month, Day, Year): March 19, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Ali J. Afrookteh, 300 West Ninth Street, Frederick, Maryland, 21701

State Registrar

31. Date filed (Month, Day, Year): MAR 20 2001
32. Registrar's Signature: Penny B Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 10330

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
FLORA VIRGINIA CUMMINGS	MARCH 17, 2001	3:15 P.M.

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Frederick Memorial Hospital	Frederick	Frederick

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
166-07-5727	1☐M 2☒F	84 Yrs.			Oct. 4, 1916	Pennsylvania

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Frederick	Frederick	1☐Yes 2☒No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
5901 Genesis Lane	21703	United States

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐Never Married 2☐Married 3☒Widowed 4☐Divorced	1☐Yes 2☒No If Yes, Give Year or Dates:	1☐Yes 2☒No Specify:	Specify: white

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12		homemaker	own home

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
James T. Marks	Virginia D. Schneck

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Ruth Horton / daughter	12316 Catoctin View Dr., Mt. Airy, MD 21771

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☐Burial 2☒Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	Hagerstown Crematory	3/19/01	Hagerstown, Maryland

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ Jacqueline L. Ware	Stauffer Funeral Homes, P.A. 8 E. Ridgeville Blvd., Mt. Airy, MD 21771

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Sepsis	Days
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of): b. Peritonitis	Days
	Due to (or as a consequence of): c.	
	Due to (or as a consequence of): d.	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month Day Year
1☐Yes 2☒No 9☐Unknown	1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?	24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐Yes 2☒No 3☐Probably 4☐Unknown	1☐Yes 2☒No	1☐Yes 2☐No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐Yes 2☒No	Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA	Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined		M	1☐Yes 2☐No	
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification; To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

29a. Certifier (Check only one)
1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ M Tolino MD	MD51610	3-18-01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Dr, Michael Tolino
1475 Taney Ave Suite 204 Frederick, MD 21701

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
MAR 19 2001	Geneva G Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 10331

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)			2. Date of Death Month	Day	Year	3. Time of Death
Esther	E.	Dorsey	March	21,	2001	6:15pm

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
WILLIAM HILL MANOR	EASTON	TALBOT

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months	Days	If Under 24 Hrs.: Hours	Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
213-74-8269	1☐ M 2☒ F	97 Yrs.					JUN 29 1903	MD

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	TALBOT	EASTON	1☒ Yes 2☐ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
501 DUTCHMAN'S LANE	21601	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced	1☐ Yes 2☒ No If Yes, Give Year or Dates:	1☐ Yes 2☒ No Specify:	Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
11	2	TEACHER	PUBLIC & PRIVATE SCHOOL

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
WILLIAM JOHN SARD	ELSIE McMAHAN

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
SYLVIA L. HACKETT/NIECE	201 GOVERNOR'S WAY QUEENSTOWN, MD 21658

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)	ST. JOHN'S CEMETERY	3-26-01	ELLICOTT CITY, MD

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ JOHN R. MERCERON CFSP	FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME PA 200 S. HARRISON ST EASTON, MD 21601

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	e. Cardiopulmonary Arrest	1hr
Due to (or as a consequence of):	ASCVD with Acute Myocardial infarction	1hr
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of): Coronary Artery Disease	10 yrs
	c. Due to (or as a consequence of):	
	d.	

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Peripheral Vascular Disease

23b. Did tobacco use contribute to the cause of death?	24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown	1☐ Yes 2☒ No	1☐ Yes 2☐ No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐ Yes 2☒ No	Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA	Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined		M	1☐ Yes 2☐ No	
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ William H. Wood Jr MD	D08715	3/22/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

WILLIAM H. WOOD JR M.D. 505 DUTCHMANS LANE EASTON, MD 21601

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
MAR 23 2001	▶ Geneva G. Sparks

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Amended item #1per MD FCHD,KS 3/23/01

Reg. No. 2001 10332

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): ~~MATHEW~~ Matthew Alan Darling ~~DARLING~~

2. Date of Death — Month: MARCH Day: 20 Year: 2001

3. Time of Death: 20:27

4a. Facility Name (If not institution, give street and number): The Johns Hopkins Hospital

4b. City, Town, or Location of Death: Baltimore City

4c. County of Death:

Funeral Director

5. Social Security Number: 219-80-3478

6. Sex: 1 X M 2 ☐ F

7. Age (In yrs. last birthday): 41 Yrs.

If Under 1 Year — Months: Days:

If Under 24 Hrs. — Hours: Min.:

8. Date of Birth (Month, Day, Year): May 1, 1959

9. Birthplace (State or Foreign Country): D.C.

Usual Residence of Decedent

10a. State: Md.

10b. County: Frederick

10c. City, Town or Location: Knoxville

10d. Inside City Limits: 1 ☐ Yes 2 X No

10e. Street and Number: 4213 Catholic Church Road

10f. Zip Code: 21758

10g. Citizen of What Country?: USA

11. Marital Status: 1 ☐ Never Married 2 X Married 3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 X No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 12

College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Installer

16b. Kind of Business/Industry: Hardwood Floore

17. Father's Name (First, Middle, Last): Lewis Edward Darling II

18. Mother's Name (First, Middle, Maiden Surname): Lois Laverne Robinson

19a. Informant's Name/Relationship (Type, Print): Katherine Darling, wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4213 Catholic Church Road, Knoxville, MD 21716

20a. Method of Disposition: 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Hagerstown Crematory

Date: 3/22/01

20c. Location - City or Town, State: Hagerstown, MD

21. Signature of Funeral Service Licensee: ▶ Barbara A. Williams

22. Name and Address of Facility: John T. Williams Funeral Home, Brunswick, MD 21716

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that ceusad tha daath. Do not antar tha moda of dying, such as cardiac or raspiretory arrast, shock, or heart failure. List only ona causa on aach lina.

Approximeta Intarval Batween Onset and Death

Immedieta Causa (Final disease or condition resulting in daath)

a. Increase Intracranial Pressure — 14 hours

Due to (or as a consequance of):

b. Intracerebral hemorrhage — 14 hours

Sequentially list conditions, if any, laading to immediete ceuse. Entar Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c. Brain aneurysm rupture — 14 hours

Due to (or as e consequenca of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Part I.

23b. **Did tobacco use contribute to the cause of death?** 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 X Yas 2 ☐ No

24b. Wara autopsy findings available prior to completion of cause of death? 1 ☐ Yas 2 X No

25. Wes casa ralarrad to medical examinar? 1 ☐ Yes 2 X No

26. Plece of Death (Check only one)

Hospital: 1 X Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA

Othar: 4 ☐ Nursing Homa 5 ☐ Residence 6 ☐ Othar (Specify)

27. Mannar of Death: 1 X Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Data of Injury (Month, Dey Year)

28b. Time of Injury M

28c. Injury at Work? 1 ☐ Yas 2 ☐ No

28d. Describe how injury occurred

28e. Plece of Injury - At home, larm, street, factory, office building, atc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one)

1 X **Certifying Physician:** To the best of my knowledga, death occurred at tha tima, data and place, and due to the cause(s) and manner as stated.

2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, daath occurred at tha tima, data and place, and due to tha ceuse(s) and mannar stated.

29b. Signatura and title of certifier: ▶ [signature] MD

29c. License number: RES-000

29d. Data signed (Month, Day, Year): March, 20, 2001

30. Nama and address of person who completed cause of death (Item 23a) (Type, Print): Michel Torbey 600 N Wolfe St. Baltimore MD 21287

State Registrar

31. Data filed (Month, Day, Year): MAR 23 2001

32. Registrar's Signature: ▶ Jenna G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than 'natural', or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 10333

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
Ethel Scott Gladhill	March 19, 2001	3:45 PM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Lorien Nursing Center	Mount Airy	Carroll

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
217-32-1317	1☐M 2☒F	90 Yrs.			Nov. 23, 1910	Maryland

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Montgomery	Damascus	1☐Yes 2☒No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
10910 Bethesda Church Road	20872	U.S.A.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐Never Married 2☒Married 3☐Widowed 4☐Divorced	1☐Yes 2☒No If Yes, Give Year or Dates:	1☐Yes 2☒No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	18b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
	2	Homemaker	Own Home

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Albert Norris Scott	Madeline King

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20872
Bernard D. Gladhill - Husband	10910 Bethesda Church Road, Damascus, Maryland

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	Damascus Methodist	March 22, 2001	Damascus, Maryland

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ Robert L. Williams	Olin L. Molesworth P.A., Funeral Home 26401 Ridge Road, Damascus, Maryland 20872

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Coronary Artery Disease	6 years
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of):	
	c. Due to (or as a consequence of):	
	d. Due to (or as a consequence of):	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month Day Year
1☐Yes 2☒No 9☐Unknown	1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?	24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐Yes 2☒No 3☐Probably 4☐Unknown	1☐Yes 2☒No	1☐Yes 2☐No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐Yes 2☒No	Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA	Other: 4☒Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined		M	1☐Yes 2☐No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification; To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one) 1☒**Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐**Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ MD	D26499	March 20, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Ronald Miller, M.D. #4 Culwell Drive, Mount Airy, Maryland 21771

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
MAR 21 2001	▶ Geneva G Sparks

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or Items 28a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 10334

Roger Greenwood

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: ROGER DALE GREENWOOD

2. Date of Death (Month, Day, Year): March 19, 2001

3. Time of Death: 1048

4a. Facility Name *(If not institution, give street and number)*: Memorial Hospital

4b. City, Town, or Location of Death: Easton

4c. County of Death: Talbot

Funeral Director

5. Social Security Number: 219-60-2077

6. Sex: 1 ☒ M 2 ☐ F

7. Age *(In yrs. last birthday)*: 48 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: SEPT 29 1952

9. Birthplace *(State or Foreign Country)*: MD

Usual Residence of Decedent

10a. State: MD

10b. County: CAROLINE

10c. City, Town or Location: PRESTON

10d. Inside City Limits: 1 ☐ Yes 2 ☒ No

10e. Street and Number: 22070 HAVERCAMP RD

10f. Zip Code: 21655

10g. Citizen of What Country?: USA

11. Marital Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 ☒ Yes 2 ☐ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* WHITE

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12; College (1-4or 5+): 0

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: CONTRACTOR

16b. Kind of Business/Industry: HEATING/AIR CONDITION

17. Father's Name *(First, Middle, Last)*: WALTER LEE GREENWOOD

18. Mother's Name *(First, Middle, Maiden Surname)*: DOROTHY MARIE LONG

19a. Informant's Name/Relationship *(Type, Print)*: MICHELLE A. GREENWOOD/WIFE

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 22079 HAVERCAMP RD, PRESTON, MD 21655

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: RIDGELY CEMETERY

Date: 3-22-01

20c. Location - City or Town, State: RIDGELY, MD

21. Signature of Funeral Service Licensee: Mary E Newnam LFSP

22. Name and Address of Facility: FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME PA 200 S. HARRISON ST EASTON, MD 21601

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Non small cell lung Cancer — 5 months

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☑ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No

26. Place of Death *(Check only one)*: Hospital: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA; Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other *(Specify)*

27. Manner of Death: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury *(Month, Day, Year)*

28b. Time of Injury: M

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 ☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: D Smith

29c. License number: D39187

29d. Date signed *(Month, Day, Year)*: 3/20/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): DAVID H. SMITH, M.D. 29466 PINTAIL DR EASTON, MD 21601

State Registrar

31. Date filed *(Month, Day, Year)*: MAR 21 2001

32. Registrar's Signature: Geneva G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 10335

Amended item#26per MD FCHD,KS 3/21/2001

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): TERINESSIA ANN HARDING

2. Date of Death: Month 03 Day 17 Year 2001

3. Time of Death: 7.45 AM.

4a. Facility Name (If not institution, give street and number): 6033 BARTONSVILLE ROAD

4b. City, Town, or Location of Death: FREDERICK CITY

4c. County of Death: FREDERICK

Funeral Director

5. Social Security Number: 212-62-3483

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 46 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): 01-10-1955

9. Birthplace (State or Foreign Country): MARYLAND

Usual Residence of Decedent

10a. State: MD.

10b. County: FREDERICK

10c. City, Town or Location: FREDERICK, MARYLAND

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 1101 KEY PARKWAY, APT. 201

10f. Zip Code: 21702

10g. Citizen of What Country? U. S. A.

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yeer or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify: BLACK

14. Race - American Indian, Black, White, etc. Specify: BLACK

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondery (0-12): 12 GRADE | College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): NURSES AID

16b. Kind of Business/Industry: FREDERICK HEALTH CARE CENTER

17. Father's Name (First, Middle, Last): WILLIAM BROOKS SR.

18. Mother's Name (First, Middle, Meiden Surname): ELEANOR ONLEY

19a. Informent's Name/Relationship (Type, Print): STEVEN LAMONT BROOKS-SON

19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code): 1101 KEY PARKWAY, APT. 201, FREDERICK, MD. 21702

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donetion 5☐ Other (Specify)

20b. Place of Disposition (Neme of cemetery, cremetory or other piece): FAIRVIEW CEMETARY

Date: 3-22-01

20c. Location - City or Town, Stete: FREDERICK, MD

21. Signature of Funeral Service Licensee: Gary L. Rollins

22. Name and Address of Facility: GARY L. ROLLINS F.H. 110 WEST SOUTH ST. FREDERICK, MD. 21701

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiratory errest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset end Death

Immediate Cause (Final disease or condition resulting in death)

a. LEIOMYOSARCOMA OF THE RIGHT PLEURAL SPACE — 3.4 YEARS

Due to (or es e consequenca of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that Initiated events resulting in deeth) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part f.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was en eutopsy performed? 1☐ Yes 2☒ No

24b. Were eutopsy findings available prior to completion of cause of deeth? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☒ Residence 6☒ Other (Specify) cousin's residence

27. Menner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury (Month, Dey Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1☒ **Certifying Physicien:** To the best of my knowledge, death occurred et the time, dete end place, end due to the cause(s) and menner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigetion, in my opinion, death occurred et the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: MD

29c. License number: D31761

29d. Date signed (Month, Dey, Year): 3/20/01

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): BRIAN M. O'CONNOR MD 501 W. SEVENTH ST. FREDERICK MD 21701

State Registrar

31. Dete filed (Month, Dey, Year): MAR 20 2001

32. Registrar's Signature: Bonnie B Sparks

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 10336

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): James Edward Harrison
2. Date of Death (Month, Day, Year): March 17, 2001
3. Time of Death: 1:45 P.M.
4a. Facility Name (If not institution, give street and number): Citizens Nursing Home
4b. City, Town, or Location of Death: Frederick
4c. County of Death: Frederick

Funeral Director

5. Social Security Number: 217-18-8275
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 78 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): August 14, 1922
9. Birthplace (State or Foreign Country): Virginia

Usual Residence of Decedent

10a. State: Maryland
10b. County: Frederick
10c. City, Town or Location: Frederick
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 1900 Rosemont Avenue
10f. Zip Code: 21702
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 7 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): General maintenance
16b. Kind of Business/Industry: Construction Products Company

17. Father's Name (First, Middle, Last): Garland Harrison
18. Mother's Name (First, Middle, Maiden Surname): Ida Cooper

19a. Informant's Name/Relationship (Type, Print): Esther V. Perkins/Daughter
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 5801 Box Elder Court, Frederick, Md. 21703

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Mt. Olivet Cemetery | Date: March 21, 2001
20c. Location - City or Town, State: Frederick, MD.

21. Signature of Funeral Service Licensee: Richard C. C. Basford M00021
22. Name and Address of Facility: Keeney and Basford Funeral Home 106 East Church Street, Frederick, Md. 21701

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Sepsis	3 days
	Due to (or as a consequence of):	
	b. Gangrene of leg	2 weeks
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of):	
	c. Peripheral vascular disease	4 years
	Due to (or as a consequence of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Chronic obstructive pulmonary disease; Congestive Heart failure

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [X] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | Other: 4 [X] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Francis E. Becker MD
29c. License number: D30496
29d. Date signed (Month, Day, Year): March 19, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Francis E. Becker, M.D., 300 West Ninth Street, Frederick, MD 21701

State Registrar

31. Date filed (Month, Day, Year): MAR 20 2001
32. Registrar's Signature: Donna G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

1- For State Registrar

Reg. No. 2001 10337

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)			2. Date of Death Month / Day / Year	3. Time of Death
EVELYN	B	HOUSTON	MARCH 21, 2001	7:58 AM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
10179 Winston Drive	Frederick	Frederick

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
213-40-2990	1☐ M 2☒ F	89 Yrs.			April 17, 1911	Virginia

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Frederick	Frederick	1☐ Yes 2☒ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
10179 Winston Drive	21701	United States

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced	1☐ Yes 2☒ No If Yes, Give Year or Dates:	1☐ Yes 2☒ No Specify:	Specify: white

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12	-	Homemaker	self

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Edwin Beazley	Evelyn S

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Mary McDowell / daughter	10179 Winston Drive, Frederick, MD 21701

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)	Carmel Baptist Church Cemetery	20 March 24,01	Ruther Glen, Virginia

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ Paul P.B. MacKay	Stauffer Funeral Homes, P.A. 1621 Opossumtown Pike, Frederick, MD 21702

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Congestive Heart Failure — 4w

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. Due to (or as a consequence of):

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month / Day / Year
1☐ Yes 2☒ No 9☐ Unknown	1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) _____ 9☐ Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Chronic Renal Failure
Diabetes Mellitus

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐ Yes 2☒ No	1☐ Yes 2☐ No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐ Yes 2☒ No	Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA	Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined		M	1☐ Yes 2☐ No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification; To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one)
1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ William H Convey, MD	D20395	March 21, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
WILLIAM H CONVEY, 195 THOMAS JOHNSON DR, FREDERICK, MD

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
MAR 23 2001	▶ Bonnie B Sparks

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 10338

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Alice Margaret Jones

2. Date of Death (Month, Day, Year): March 21 2001

3. Time of Death: 6:00p.m.

4a. Facility Name (If not institution, give street and number): 7820 Two Johns Road

4b. City, Town, or Location of Death: Preston

4c. County of Death: Caroline

Funeral Director

5. Social Security Number: 217-24-5600

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 74 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Dec.19,1926

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: MD

10b. County: Caroline

10c. City, Town or Location: Preston

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 7820 Two Johns Road

10f. Zip Code: 21655

10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yeer or Dates:

13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No Specify:

14. Race - American Indien, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondery (0-12): 12 | College (1-4or 5+): 2

16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired): Organist

16b. Kind of Business/Industry: Musician

17. Father's Neme (First, Middle, Last): Robert Z. Gartrell

18. Mother's Neme (First, Middle, Maiden Surneme): Thelma Rosa Keen

19a. Informent's Neme/Reletionship (Type, Print): C.Robert Jones/Husband

19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code): 7820 Two Johns Rd. Preston, MD 21655

20a. Method of Disposition: 1☒ Burial 2☐ Cremetion 3☐ Removal from State 4☐ Donetion 5☐ Other (Specify)

20b. Piece of Disposition (Neme of cemetery, cremetory or other place): Jr. Order cemetery

Dete: 3/24/01

20c. Location - City or Town, Stete: Preston, Maryland

21. Signature of Funerel Service Licensee: Michael F. Eskow

22. Neme end Address of Fecility: Framptom-Hawkins-Eskow Funeral Home,PA 216 N. Main St.Federalsburg, MD 21632

Physician /Medical Examiner

23a. Part1. Enter the disease, or complicetions thet caused the deeth. Do not enter the mode of dying, such es cardiec or respiretory arrest, shock, or heart failure. List only one cause on each line.

Approximete Intervel Between Onset and Death

Immediete Cause (Finel disease or condition resulting in death)

a. Breast Cancer — 12yrs

Due to (or es e consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury thet initieted events resulting in death) Last

b.

Due to (or es e consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Wes en eutopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings aveileble prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Piece of Deeth (Check only one): Hospitel: 1☐ Inpatient 2☐ ER/Outpetient 3☐ DOA Other: 4☐ Nursing Home 5☑ Residence 6☐ Other (Specify)

27. Menner of Death: 1☑ Netural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined

28a. Dete of Injury (Month, Dey Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Piece of Injury - At home, ferm, street, fectory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) end menner es steted.
2☐ **Medical Examiner:** On the besis of exemineticn and/or investigetion, in my opinion, deeth occurred at the time, dete end place, and due to the cause(s) and menner steted.

29b. Signature and title of certifier: David H Smith

29c. License number: D39887

29d. Dete signed (Month, Day, Year): 3/22/01

30. Neme and address of person who completed cause of deeth (Item 23a) (Type, Print): David H. Smith MD 29466 Pintail Dr Ste5 Easton MD 21601

State Registrar

31. Date filed (Month, Dey, Year): MAR 23 2001

32. Registrer's Signeture: Donna G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 10339

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
Howard Jennings, Jr.	March 13, 2001	10:30 AM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Frederick memorial Hospital	Frederick	Frederick

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
214-30-2029	X 1 M 2 F	69 Yrs.			Nov. 3, 1931	MD.

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD.	Frederick	Frederick	1 ☐ Yes 2 ☒ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
8209 Gambrill Park Rd.	21702	U.S.A.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:	1 ☐ Yes 2 ☒ No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	18b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)	engineer	electrical
	2		

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Howard J. Jennings	Mildred Whitehair

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Marie Jennings (Wife)	8209 Gambrill Park Rd., Frederick, MD. 21702

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	Reformed Cemetery	3/16	Middletown, MD.

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ [signature]	Donald B. Thompson Funeral Home 31 E. Main St., Middletown, MD. 21769

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

Medical Certification; To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. INTRACEREBRAL HEMORRHAGE	24 HOURS
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of):	
	c. Due to (or as a consequence of):	
	d. Due to (or as a consequence of):	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown	23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?	24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown	1 ☐ Yes 2 ☒ No	1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1 ☐ Yes 2 ☒ No	Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA	Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined		M	1 ☐ Yes 2 ☐ No	
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)	
1 ☒	**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐	**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ [signature] MD	D37501	3/13/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
BOYD A. DWYER MD 172 THOMAS JOHNSON DRIVE SUITE 100 FREDERICK, MD 21702

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
MAR 19 2001	▶ [signature]

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 10340

William Little

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

Funeral Director

To Be Completed by Funeral Director

1. Decedent's Name (First, Middle, Last): William Little, Jr.

2. Date of Death: Month March Day 14 Year 2001

3. Time of Death: 0135

4a. Facility Name (If not institution, give street and number): The Memorial Hospital

4b. City, Town, or Location of Death: Easton

4c. County of Death: Talbot

5. Social Security Number: 218-20-6226

6. Sex: 1☒M 2☐F

7. Age (In yrs. last birthday): 76 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Sept. 20, 1924

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Queen Annes

10c. City, Town or Location: Grasonville

10d. Inside City Limits: 1☐Yes 2☒No

10e. Street and Number: 309 Sawmill Road

10f. Zip Code: 21638

10g. Citizen of What Country?: USA

11. Marital Status: 1☐Never Married 2☒Married 3☐Widowed 4☐Divorced

12. Was Decedent Ever in U.S. Armed Forcas? 1☐Yas 2☒No If Yes, Giva Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No Specify:

14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 6 / College (1-4or 5+):

16a. Decedent's Usual Occupation (Giva kind of work done during most of working life. DO NOT use retired): Disposable Attendant

16b. Kind of Business/Industry: Queen Annes County

17. Father's Name (First, Middle, Last): William Little, Sr.

18. Mother's Name (First, Middle, Maiden Surname): Marion Decton

19a. Informant's Name/Raiationship (Type, Print): Lucille Little / Wife

19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code): P.O.Box 613, Grasonville,Maryland 21638

20a. Mathod of Disposition: 1☒Burial 2☐Cremation 3☐Ramoval from State 4☐Donation 5☐Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other piece): Bryans Cemetery

Date: 3/17/2001

20c. Location - City or Town, Stata: Grasonville,Md.

21. Signature of Funeral Service Licensee: John A. Prince

22. Name and Address of Facility: Bennie Smith Funeral Home 426 Dover Street,Maryland 21601

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the diseasa, or complications that caused the death. Do not enter the mode of dying, such as cardiac or raspiratory arrast, shock, or heart failure. List only one cause on each line.

Approximata Interval Between Onset and Death

Immediata Causa (Final disease or condition resulting in death)

a. Hypotension

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or Injury that initiated evants rasulting in death) Last

b. Ventricular Tachycardia

Dua to (or as a consequance of):

c.

Dua to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: End staye Renal disease

23b. Did tobacco use contribute to the cause of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

24a. Was en autopsy performed? 1☐Yas 2☒No

24b. Were autopsy findings available prior to compiation of cause of death? 1☐Yas 2☐No

25. Was casa referred to medical examinar? 1☐Yes 2☒No

26. Place of Death (Check only one): Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA Othar: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death: 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

28a. Date of Injury (Month, Dey Year)

28b. Time of Injury M

28c. Injury at Work? 1☐Yes 2☐No

28d. Describe how injury occurred

28e. Place of Injury - At homa, farm, street, factory, offica building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, Stata)

29a. Certifier (Check only one): 1☒**Certifying Physician**: To the best of my knowledga, daath occurred at tha time, data and place, and due to the cause(s) and mannar as stated. 2☐**Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the tima, data and placa, and due to the cause(s) and mannar stated.

29b. Signature and title of certifier: Noel Hunte

29c. License number: D0055225

29d. Date signed (Month, Day, Year): 3/14/01

30. Name and addrass of person who completed cause of death (Item 23a) (Type, Print): Noel Hunte,M.D. , 219 south Washington Street,Easton,Maryland 21601

State Registrar

31. Date filed (Month, Day, Year): MAR 19 2001

32. Registrar's Signatura: Geneva G. Sparks

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 10341

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)			2. Date of Death Month	Day	Year	3. Time of Death
HELEN	GENEVIEVE	ONEY	MARCH	21,	2001	8:30 P M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Frederick Memorial Hospital	Frederick	Frederick

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months	Days	If Under 24 Hrs.: Hours	Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
199-09-6526	1☐M 2☒F	85 Yrs.					March 18, 1916	Pennsylvania

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
PA	Monroe	Stroudsburg	1☐Yes 2☒No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
316 Oakwood Avenue	18360	United States

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐Never Married 2☐Married 3☒Widowed 4☐Divorced	1☐Yes 2☒No If Yes, Give Year or Dates:	1☐Yes 2☒No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12		Homemaker	Own Home

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Lawrence Keller	Margaret Kennedy

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Elaine Foulkes / Daughter	11051 Pleasant Walk Rd. Myersville, MD 21773

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☐Burial 2☒Cremation 3☐Removal from State 4☐Donetion 5☐Other (Specify)	Resthaven Crematory	March 23, 2001	Frederick, Maryland

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶	Skkot Cody (Licensed Mortician) 44 Tremaine Ct. Baltimore, MD 21244

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. ACUTE Myocardial Infarction	5 days
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of): Cardiomyopathy	5 days
	c. Due to (or as a consequence of): Coronary Artery Disease	5 days
	d. Due to (or as a consequence of):	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month Day Year
1☐Yes 2☐No 9☐Unknown	1☐Live birth 2☐Fetel death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobecco use contribute to the cause of death?	24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐Yes 2☒No 3☐Probably 4☐Unknown	1☐Yes 2☒No	1☐Yes 2☐No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐Yes 2☒No	Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA	Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined		M	1☐Yes 2☐No	
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification; To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one) 1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and menner as steted. 2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Yaar)
▶	D36149	3/22/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Edward P. Riuli, M.D. 180 Thomas Johnson Dr. Frederick, MD 21702

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
MAR 23 2001	▶ Donna G Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

1- For State Registrar

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 10342

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Elizabeth M Russell
2. Date of Death: Month March Day 20, Year 2001
3. Time of Death: 10:36 AM
4a. Facility Name (If not institution, give street and number): Frederick Memorial Hospital
4b. City, Town, or Location of Death: Frederick
4c. County of Death: Frederick

Funeral Director

5. Social Security Number: 175-05-2501
6. Sex: 1☐M 2☒F
7. Age (In yrs. last birthday): 90 Yrs. — If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Oct. 26, 1910
9. Birthplace (State or Foreign Country): Pennsylvania

Usual Residence of Decedent

10a. State: Maryland
10b. County: Frederick
10c. City, Town or Location: Frederick
10d. Inside City Limits: 1☐Yes 2☒No
10e. Street and Number: 7919 Juniper Drive
10f. Zip Code: 21702
10g. Citizen of What Country?: United States

11. Marital Status: 1☐Never Married 2☐Married 3☒Widowed 4☐Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐Yes 2☒No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Kitchen Manager
16b. Kind of Business/Industry: Boiler Plant

17. Father's Name (First, Middle, Last): Frank Ovecka
18. Mother's Name (First, Middle, Maiden Surname): Anna Ballas

19a. Informant's Name/Relationship (Type, Print): Kathryn E. McGee / DAughter
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 7919 Juniper Drive Frederick, Maryland 21702

20a. Method of Disposition: 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Odd Fellows Cemetery
Date: March 24 2001
20c. Location - City or Town, State: Tamaqua, Pennsylvania

21. Signature of Funeral Service Licensee: ▶ Debra J Fortson
22. Name and Address of Facility: Stauffer Funeral Homes, P.A. 1621 Opossumtown Pike Frederick, Maryland 21702

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
e. Ischemic Cardiomyopathy — 2 months

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. Coronary Artery Disease — 20 years

Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐Yes 2☒No 9☐Unknown
23c. If yes, outcome of pregnancy: 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown
23d. Date of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

24a. Was an autopsy performed? 1☐Yes 2☒No
24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☐No

25. Was case referred to medical examiner? 1☐Yes 2☒No

28. Place of Death (Check only one)
Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA
Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death: 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐Yes 2☐No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Mary P. Howell MD
29c. License number: D46075
29d. Date signed (Month, Day, Year): 3/20/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): 170 THOMAS JOHNSON DRIVE #100 FREDERICK MD 21702

State Registrar

31. Date filed (Month, Day, Year): MAR 23 2001
32. Registrar's Signature: ▶ Jenna G Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Medical Certification; To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

Amended item#23a,(perMD),03-20-01,SRR,Talbot

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 10343

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
DALE HOPKINS RADCLIFFE	March 17, 2001	11:00 a.m,.

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
214 A. North St.	St. Michaels	Talbot

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
218-20-8690	X 1 M 2 F	72 Yrs.			SEPT. 28, 1928	Maryland

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Talbot	St. Michaels	X 1 Yes 2 No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
214 A. North St,	21663	U.S.A.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1 Never Married 2 Married 3 X Widowed 4 Divorced	1 X Yes 2 No If Yes, Give Year or Dates: U.S. Army	1 Yes 2 X No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
10		Waterman	Seafood

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Roy Radcliffe Sr.	Sarah Elizabeth Sullivan

19a. Informent's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Dawn Dionne Daughter	146 Sillery Bay Rd. Pasadena, Maryland 21122

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify)	Capitol Crematory	3-19-2001	Dover, Delaware

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
Harrison E Leonard	Harrison E. Leonard Funeral Home 312 S. Talbot St. St. Michaels, Maryland 21663

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. ~~UNKNOWN PRIMARY FOUND AT AUTOPSY~~ Pharyngeal Squamous Cell Carcinoma

Due to (or as a consequence of):

b. ~~PHARYNGEAL SQUAMOUS CELL CARCINOMA~~

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c. CHRONIC OBSTRUCTIVE PULMONARY DISEASE

Due to (or as a consequence of):

d. CEREBRAL VASCULAR ACCIDENT

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

CORONARY ARTERY DISEASE

HYPERTENSION

CHRONIC PANCREATITIS

23b. Did tobacco use contribute to the cause of death? X 1 Yes 2 No 3 Probably 4 Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1 Yes X 2 No	1 Yes 2 No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1 Yes X 2 No	Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA	Other: 4 Nursing Home X 5 Residence 6 Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
X 1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined		M	1 Yes 2 No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): X 1 **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
	D0045917	3/19/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Matthew B. Troshinsky M.D. 511 Idlewild Ave. Easton, Maryland 21601

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
MAR 20 2001	G. Sparks

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

SBB

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar Amended item#5 FCHD,KS 3/22/01

Certificate of Death

2001 10344
Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death (Month, Day, Year)	3. Time of Death
Gertrude Elizabeth Roberts	March 21, 2001	6:50 a. M.

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
FREDERICK MEMORIAL HOSPITAL	FREDERICK	FREDERICK

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
~~212-05-7031~~ ~~215-05-7031~~	1☐ M 2☒ F	94 Yrs.			JAN.28,1907	GETTYSBURG,PA.

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	FREDERICK	THURMONT	1☒ Yes 2☐ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
16 W. MAIN ST.	21788	U. S. A.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced	1☐ Yes 2☒ No If Yes, Give Year or Dates:	1☐ Yes 2☒ No Specify:	Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
	2	SECRETARY	GAS & ELECTRIC

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
J. LEWIS TOPPER	MARGARET E. FLORENCE

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
MARY J. ARCIDIACONO	1121 FAIRVIEW RD., HAGERSTOWN, MD. 21742

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)	SMITHSBURG CREMATORIUM	3/22/01	SMITHSBURG, MD.

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
John M. Skiles	SKILES FUNERAL HOME 210 W. MAIN ST., EMMITSBURG, MD. 21727-0427

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. INTRACRANIAL HEMMORHAGE	48 Hrs.
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of):	
	c. Due to (or as a consequence of):	
	d. Due to (or as a consequence of):	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery (Month, Day, Year)
1☐ Yes 2☒ No 9☐ Unknown	1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) _____ 9☐ Unknown	

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?	24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown	1☐ Yes 2☒ No	1☐ Yes 2☐ No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐ Yes 2☒ No	Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA	Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	26c. Injury at Work?	28d. Describe how injury occurred
1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined		M	1☐ Yes 2☐ No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
Ravi Yalamanchile	D0044213	3/21/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
RAVI YALAMANCHILE, MD. 198 THOMAS JOHNSON DR., FREDERICK, MD. 21702

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
MAR 22 2001	Donna B Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than 'natural', or Item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 10345

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): HAZEL POTTER RUWET
2. Date of Death: Month March Day 21, Year 2001
3. Time of Death: 10:28 PM
4a. Facility Name (If not institution, give street and number): Northampton Manor Nursing Home
4b. City, Town, or Location of Death: Frederick
4c. County of Death: Frederick

Funeral Director

5. Social Security Number: 042-12-3232
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 81 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Sept. 7, 1919
9. Birthplace (State or Foreign Country): Connecticut

Usual Residence of Decedent

10a. State: Maryland
10b. County: Frederick
10c. City, Town or Location: Frederick
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 209 Crestview Court
10f. Zip Code: 21702
10g. Citizen of What Country? U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12) | College (1-4or 5+): 4
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker
16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): Harry Everett Potter
18. Mother's Name (First, Middle, Maiden Surname): Willie Edna Welles

19a. Informant's Name/Relationship (Type, Print): John W. Ruwet (Son)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 6132 Long Branch Rd., Frederick, Maryland 21701

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Smithsburg Crematory
Date: 3/22/01
20c. Location - City or Town, State: Smithsburg, Maryland

21. Signature of Funeral Service Licensee: Robert E. Dailey
22. Name and Address of Facility: ROBERT E. DAILEY & SON FUNERAL HOMES, P.A. 1201 NORTH MARKET ST., FREDERICK, MD 21701

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. CVA - — 1 mo.

~~Due to~~ (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 8☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: Robert L. Kaufmann
29c. License number: D-13971
29d. Date signed (Month, Day, Year): 3/22/01
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Robert L. Kaufmann, MD 300 West Ninth Street, Frederick, Maryland 21701

State Registrar

31. Date filed (Month, Day, Year): MAR 23 2001
32. Registrar's Signature: Joan B Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 10346

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Emma Jeanette Sullivan

2. Date of Death (Month, Day, Year): March 18 2001

3. Time of Death: 8:50pm

4a. Facility Name *(If not institution, give street and number)*: Lorien Nursing Home

4b. City, Town, or Location of Death: Mt. Airy

4c. County of Death: Carroll

Funeral Director

5. Social Security Number: 042-16-4159

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 85 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Jan, 25,1916

9. Birthplace *(State or Foreign Country)*: Vermont

Usual Residence of Decedent

10a. State: Maryland

10b. County: Howard

10c. City, Town or Location: Woodbine

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 17487 Timberleigh Way

10f. Zip Code: 21797

10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yeer or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12) | College (1-4or 5+): 1

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Homemaker

16b. Kind of Business/Industry: Own Home

17. Father's Name *(First, Middle, Last)*: Edmond LaFranchise

18. Mother's Name *(First, Middle, Maiden Surname)*: Emma DeLaurier

19a. Informant's Name/Relationship *(Type, Print)*: Leslie A. Vaccari/ Daughter

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 17487 Timberleigh Way, Woodbine, Maryland 21797

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Metropolitan Crematorium | Date: 3/20/01

20c. Location - City or Town, State: Alexandria, Virginia

21. Signature of Funeral Service Licensee: ▶ Olin L. Molesworth

22. Name and Address of Facility: Olin L. Molesworth P. A., Funeral Home 26401 Ridge Road, Damascus, Maryland 20872

Physician /Medical Examiner

23a. Part1. Enter the diseese, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory errest, shock, or heert failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Hypertensive cardiovascular disease — Approximate Interval: 4 years.

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or Injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Dementia

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Wes an autopsy performed? 1☐ Yes 2☑ No

24b. Were eutopsy findings available prior to completion of ceuse of death? 1☐ Yes 2☐ No

25. Was cese referred to medicet examiner? 1☐ Yes 2☑ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☑ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Menner of Death: 1☑ Netural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)* | 28b. Time of Injury M | 28c. Injury at Work? 1☐ Yes 2☐ No | 28d. Describe how injury occurred

28e. Piece of Injury - At home, ferm, street, factory, office building, etc. *(Specify)* | 28f. Location *(Street and Number or Rural Route Number, City or Town, Stete)*

29a. Certifier *(Check only one)*: 1☑ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ MD

29c. License number: D26499

29d. Date signed *(Month, Day, Year)*: March 20, 2001

30. Name and address of person who completed ceuse of death (Item 23a) (Type, Print): Ronald Miller MD #4 Culwell Drive, Mt. Airy, Maryland 21771

State Registrar

31. Date filed *(Month, Day, Year)*: MAR 21 2001

32. Registrar's Signature: ▶ Jenna G Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

01-1560-021
crn
Melissa Stewart

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 10347

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month / Day / Year	3. Time of Death
Melissa MaryEm Stewart	March 20 2001	9:08 A M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Frederick Memorial Hospital	Frederick	Frederick

Funeral Director

5. Social Security Number	8. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
377-82-9191	1☐M 2☒F	23 Yrs.			April 4, 1977	Michigan

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Frederick	Walkersville	1☐Yes 2☒No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
8396 Inspiration Avenue	21793	United Stated

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☒Never Married 2☐Married 3☐Widowed 4☐Divorced	1☐Yes 2☒No If Yes, Give Year or Dates:	1☐Yes 2☒No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12		Collections Agent	Banking

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Meiden Surneme)
Tommy C. Stewart	Linda Ann Piatowski

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code)
Linda A. Stewart / Mother	8396 Inspiration Avenue Walkersville, Maryland21793

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☐Burial 2☒Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	Hagerstown Crematory	March 23, 2001	Hagerstown, Maryland

21. Signature of Funeral Service Licensee ▶ [signature]

22. Name and Address of Facility Stauffer Funeral Homes, P.A. 1621 Opossumtown Pike Frederick, Maryland 21702

Physician /Medical Examiner

Medical Certification; To Be Completed by Physician/Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Finat disease or condition resulting in death)

a. Hemoperitoneum

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Ruptured Tubal Ectopic Pregnancy

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month / Day / Year
1☒Yes 2☐No 9☐Unknown	1☐Live birth 2☐Fetal death 3☑Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☒Yes 2☐No	1☒Yes 2☐No

25. Was case referred to medical examiner? 1☒Yes 2☐No

28. Place of Death (Check only one)

Hospital: 1☐Inpatient 2☒ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death: 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

28a. Date of Injury (Month, Dey Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
	M	1☐Yes 2☐No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rurel Route Number, City or Town, Stete)

29a. Certifier (Check only one) 1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☒ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Dey, Yeer)
▶ J Pestaner, M.D.	O.C.M.E.	March 21, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Joseph Pestaner 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
MAR 23 2001	▶ Penny B Sparks

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar Amended Line 15 jd, fchd *Certificate of Death*

Reg. No. 2001 10348

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month / Day / Year	3. Time of Death
AUDREY BERNICE STATON	MARCH 21 2001	5:45 P M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Frederick Memorial Hospital	Frederick	Frederick

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
215-26-1637	1☐M 2☒F	78 Yrs.			Mar. 31, 1922	Maryland

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Frederick	Frederick	1☒Yes 2☐No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
429 South Market Street	21701	U.S.A.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐Never Married 2☐Married 3☒Widowed 4☐Divorced	1☐Yes 2☒No If Yes, Give Year or Dates:	1☐Yes 2☒No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	18b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12	12	Cafeteria Worker	Elementary School

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Charles Shultz	Della Gaver

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Linda Ferree (Daughter)	427 South Market Street, Frederick, Maryland 21701

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	Mount Olivet Cemetery	3/26/01	Frederick, Maryland

21. Signature of Funeral Service Licensee: Robert E. Dailey

22. Name and Address of Facility: ROBERT E. DAILEY & SON FUNERAL HOMES, P.A. 1201 NORTH MARKET ST., FREDERICK, MD 21701

Physician /Medical Examiner

23a. Part I. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or head failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) a.	Congestive heart failure	1 day
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of):	Alzheimer's dis. (dementia)	2 yrs
c. Due to (or as a consequence of):		
d.		

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month / Day / Year
1☐Yes 2☒No 9☐Unknown	1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐Yes 2☒No	1☐Yes 2☐No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐Yes 2☒No	Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA	Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined		M	1☐Yes 2☐No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification; To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
Robert S. Hughes	D0511	3/22/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Robert S. Hughes, MD 700 Montclaire Avenue, Frederick, MD 21701

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
MAR 23 2001	Donna B Sparks

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 | 0349

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
VIOLA ELIZABETH STULL	MARCH 22, 2001	3:45 AM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Frederick Memorial Hospital	Frederick	Frederick

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
216-18-8118	1☐ M 2☒ F	82 Yrs.			Feb 4, 1919	Maryland

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Frederick	Frederick	1☐ Yes 2☒ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
5530 Ballenger Creek Pike	21703	U.S.A.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced	1☐ Yes 2☒ No If Yes, Give Yeer or Detes:	1☐ Yes 2☒ No Specify:	Specify: White

15. Decedent's Education (Specify only highest grede completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
9		Seamstress	Sewing Factory

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Harry C Shank	Elsie Hotlzapple

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Mr Ronald Buffington/Son	7909 Fingerboard Road, Frederick, Maryland 21704

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donetion 5☐ Other (Specify)	Mt Olivet Cemetery	Mar 24, 2001	Frederick, Maryland

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
Kathryn A Berson M00706	Keeney & Basford P.A. Funeral Home 106 East Church St, Frederick, Maryland 21701

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Finel disease or condition resulting in death)	a. Metastatic lung cancer	3 months
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last	b. Due to (or as a consequence of):	
	c. Due to (or as a consequence of):	
	d. Due to (or as a consequence of):	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month Day Year
1☐ Yes 2☒ No 9☐ Unknown	1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of deeth 5☐ Other (specify) _____ 9☐ Unknown	

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐ Yes 2☒ No	1☐ Yes 2☐ No

Medical Certification; To Be Completed by Physician/Medical Examiner

25. Wes case referred to medical examiner?	28. Place of Death (Check only one)	
1☐ Yes 2☒ No	Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA	Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Menner of Deeth	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined		M	1☐ Yes 2☐ No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, end due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
William A. Milkey MD	D14373	3/23/01

30. Name end address of person who completed cause of death (Item 23a) (Type, Print)

William A. Milkey MD 8009 Talbert Frederick, MD 21701

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
MAR 23 2001	Donna B Sparks

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Amended #2, #3, per ~~PH~~ MD, TCHD, 3/22/01, shs

Certificate of Death

Reg. No. 2001 10350

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): LOUISE ROE TOPE

2. Date of Death: Month MARCH Day ~~21~~ 20 Year 2001

3. Time of Death: 5:30 ~~AM~~ PM

4a. Facility Name (If not institution, give street and number): 5691 PIRATES COVE RD

4b. City, Town, or Location of Death: OXFORD

4c. County of Death: TALBOT

Funeral Director

5. Social Security Number: 579-60-7969

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 92 Yrs.

If Under 1 Year: Months ___ Days ___

If Under 24 Hrs.: Hours ___ Min. ___

8. Date of Birth (Month, Day, Year): FEB 5 1909

9. Birthplace (State or Foreign Country): ALABAMA

Usual Residence of Decedent

10a. State: MD

10b. County: TALBOT

10c. City, Town or Location: OXFORD

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 5691 PIRATES COVE RD

10f. Zip Code: 21654

10g. Citizen of What Country: USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 11; College (1-4 or 5+): 4

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): HOMEMAKER

16b. Kind of Business/Industry: OWN HOME

17. Father's Name (First, Middle, Last): JAMES KNOX ROE

18. Mother's Name (First, Middle, Maiden Surname): JESSIE MAY BLAIR

19a. Informant's Name/Relationship (Type, Print): SARAH B. SADLER/DAUGHTER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 5691 PIRATES COVE RD OXFORD, MD 21654

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): REHOBETH PRESBYTERIAN CHURCH CEMETERY OF MIDWAY

Date: 3-24-01

20c. Location - City or Town, State: REHOBETH BEACH, DE

21. Signature of Funeral Service Licensee: Mona S. Newnam CFSP

22. Name and Address of Facility: FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME PA 200 S. HARRISON ST EASTON, MD 21601

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Congestive Heart Failure — 2 days

Due to (or as a consequence of): b. Sick Sinus Syndrome

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

Due to (or as a consequence of): c.

Due to (or as a consequence of): d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Dementia - Alzheimers

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☒ Residence 8☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature]

29c. License number: D47492

29d. Date signed (Month, Day, Year): 3/21/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): JEFFREY DENTON, M.D. 555 CYNWOOD DR. EASTON, MD 21601

State Registrar

31. Date filed (Month, Day, Year): MAR 22 2001

32. Registrar's Signature: Geneva G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

SHS

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 10351

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Aaron Leo Tucker
2. Date of Death (Month Day Year): March 18, 2001
3. Time of Death: 8:20 AM
4a. Facility Name (If not institution, give street and number): 400 East Ninth Street
4b. City, Town, or Location of Death: Frederick
4c. County of Death: Frederick

Funeral Director

5. Social Security Number: 214-10-2969
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 85 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Aug. 25, 1915
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Frederick
10c. City, Town or Location: Frederick
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 400 East Ninth Street
10f. Zip Code: 21701
10g. Citizen of What Country: USA

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 6; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): salesman
16b. Kind of Business/Industry: furniture sales

17. Father's Name (First, Middle, Last): William Christian Tucker, Jr.
18. Mother's Name (First, Middle, Maiden Surname): Catherine ELizabeth Hutzell

19a. Informant's Name/Relationship (Type, Print): Judy Ledbetter, niece
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 7321 Granalta Circle, Frederick, MD 21702

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Mt. Olivet Cemetery
Date: 3/21/2001
20c. Location - City or Town, State: Frederick, Maryland

21. Signature of Funeral Service Licensee: ▶ Ryan M. Berger M00999
22. Name and Address of Facility: Keeney and Basford Funeral Home, 106 East Church Street, Frederick, MD 21701

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Myocardial Infarction
Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. Hypertension
Due to (or as a consequence of):
c. Diabetes Mellitus
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No
26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify)
27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician**: To the best of *my* knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: ▶ Edward Fisher MD
29c. License number: D0036610
29d. Date signed (Month, Day, Year): March 19, 2001
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Edward Fisher, MD, 56 Thomas Johnson Drive, Frederick, MD 21702

State Registrar

31. Date filed (Month, Day, Year): MAR 20 2001
32. Registrar's Signature: ▶ Geneva B Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No: 2001 10352

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): HAJO FREDERICK TJADEN

2. Date of Death (Month, Day, Year): MARCH 20, 2001

3. Time of Death: 1130 am

4a. Facility Name (If not institution, give street and number): 303 COLLINS AVENUE

4b. City, Town, or Location of Death: HURLOCK

4c. County of Death: DORCHESTER

Funeral Director

5. Social Security Number: 217-36-1056

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 87 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): JUNE 9, 1913

9. Birthplace (State or Foreign Country): MARYLAND

Usual Residence of Decedent

10a. State: MARYLAND

10b. County: DORCHESTER

10c. City, Town or Location: HURLOCK

10d. Inside City Limits: 1 [X] Yes 2 [ ] No

10e. Street and Number: 303 COLLINS AVENUE

10f. Zip Code: 21643

10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 6 | College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): FARMER

16b. Kind of Business/Industry: AGRICULTURE

17. Father's Name (First, Middle, Last): JOHN JOHNSON TJADEN

18. Mother's Name (First, Middle, Maiden Surname): HILDA MATILDA KNAACK

19a. Informant's Name/Reletionship (Type, Print): HILDA M. THOMAS

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 5347 JONES THICKET ROAD, VIENNA, MARYLAND 21869

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, cremetory or other place): JUNIOR ORDER CEMETERY

Date: 3/23/01

20c. Location - City or Town, State: PRESTON, MARYLAND

21. Signature of Funeral Service Licensee: Leonard D. Zeller

22. Name and Address of Facility: ZELLER FUNERAL HOME, P. O. BOX 207, 106 MAIN STREET, EAST NEW MARKET, MD 21631

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death):
a. Cardiac Arrhythmia — 4 min

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting in death) Last:
b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Adult Diabetes

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Michael Fiddler MD

29c. License number: D26355

29d. Date signed (Month, Day, Year): March 21 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Michael Fiddler MD 302 Collins, Hurlock Md 21643

State Registrar

31. Date filed (Month, Day, Year): MAR 23 2001

32. Registrar's Signature: Donna G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 10353

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Dey Year	3. Time of Death
MARGARET A. WARD	March 20, 2001	1417 M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
The Memorial Hospital	Easton	Talbot

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
218-26-2566	1☐M 2☒F	70 Yrs.			MAR 12 1931	MD

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	TALBOT	EASTON	1☒Yes 2☐No

10e. Street and Number	10f. Zip Code	10g. Citizen of Whet Country?
12 ALBION COURT	21601	USA

11. Maritaf Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Bleck, White, etc.
1☐Never Married 2☒Married 3☐Widowed 4☐Divorced	1☐Yes 2☒No If Yes, Give Year or Dates:	1☐Yes 2☒No Specify:	Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	Cottege (1-4or 5+)		
11	0	CLERICAL	BANKING

17. Father's Name (First, Middle, Last)	18. Mother's Neme (First, Middle, Maiden Surname)
WALTER EUGENE COOPER	MARY CHRISTINA BAKER

19a. Informant's Name/Relationship (Type, Print)	19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
WALTER M. WARD/HUSBAND	12 ALBION CT, EASTON, MD 21601

20a. Method of Disposition	20b. Ptece of Disposition (Name of cemetery, crematory or other place)	Dete	20c. Location - City or Town, State
1☒Burial 2☐Cremation 3☐Removal from Stete 4☐Donation 5☐Other (Specify)	MD VETERANS CEMETERY	3-23-01	HURLOCK, MD

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ JOHN R. MERCERON CFSP	FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME PA 200 S. HARRISON ST EASTON, MD 21601

To Be Completed by Funeral Director

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory errest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Pulmonary Edema	14 days
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as e consequence of):	
	c. Due to (or es e consequence of):	
	d. Due to (or es e consequence of):	

IF FEMALE: 23b. Wes decedent pregnant in the past 12 months? 1☐Yes 2☒No 9☐Unknown	23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant et time of death 5☐Other (specify) 9☐Unknown	23d. Dete of delivery Month Dey Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

- Acute Respiratory Distress Syndrome
- Non Transmural Myocardial Infarction

23e. Did tobecco use contribute to the ceuse of death?	24a. Was en autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐Yes 2☐No 3☐Probably 4☒Unknown	1☐Yes 2☒No	1☐Yes 2☒No

25. Was case referred to medical examiner?	26. Place of Deeth (Check only one)	
1☐Yes 2☒No	Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA	Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death	26a. Date of Injury (Month, Day Year)	26b. Time of Injury	26c. Injury at Work?	26d. Describe how injury occurred
1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined		M	1☐Yes 2☐No	
	26e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			26f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification; To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one)	
1☒	**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end manner es steted.
2☐	**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, dete end plece, end due to the cause(s) end manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ J M D Shields	D0053110	3/20/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DENNIS M. DESHIELDS M.D. 219 S. WASHINGTON ST EASTON, MD 21601

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
MAR 2 2 2001	▶ Geneva G. Sparks

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Item 23a or 26a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

Margaret Ward

SHS

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 10354

Physician /Medical Examiner

1. Decedent's Neme (First, Middle, Last): William Henry Wilson
2. Date of Deeth — Month: March, Dey: 17, Year: 2001
3. Time of Deeth: 5:45am
4e Facility Neme (If not institution, give street end number): William Hill Manor
4b. City, Town, or Location of Deeth: EASTON
4c. County of Deeth: TALBOT

Funeral Director

5. Socie! Security Number: 276-32-5801
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 88 Yrs.
If Under 1 Year — Months: Deys:
If Under 24 Hrs. — Hours: Min.:
8. Dete of Birth (Month, Day, Year): MARCH 18, 1912
9. Birthplace (State or Foreign Country): SCOTLAND

Usuel Residence of Decedent

10a. Stete: MD
10b. County: TALBOT
10c. City, Town or Locetion: ST. MICHAELS
10d. Inside City Limits: 1 [ ] Yes [X] No
10e. Street and Number: 6975 PEA NECK RD
10f. Zip Code: 21663
10g. Citizen of Whet Country?: USA

11. Meritel Stetus: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced
12. Wes Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Wes Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Rece - American Indien, Bleck, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grede completed): Elementary/Secondary (0-12): 12; College (1-4or 5+): 0
16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired): CLAIMS INSPECTOR
16b. Kind of Business/Industry: STATE GOVT.

17. Father's Neme (First, Middle, Last): WILLIAM WILSON
18. Mother's Neme (First, Middle, Maiden Surname): JANE TURNER

19e. Informent's Neme/Reletionship (Type, Print): WILLIAM L. WILSON/SON
19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code): 6975 PEA NECK RD ST. MICHAELS, MD 21663

20e. Method of Disposition: 1 [ ] Buriel 2 [X] Cremetion 3 [ ] Removal from State 4 [ ] Donetion 5 [ ] Other (Specify)
20b. Place of Disposition (Neme of cemetery, cremetory or other place): CHESAPEAKE CREMATION CTR
Date: 3-19-01
20c. Location - City or Town, Stete: STEVENSVILLE, MD

21. Signeture of Funeral Service Licensee: Mann E Mann Jr CFSP
22. Neme end Address of Fecility: FELLOWS,HELFENBEIN & NEWNAM FUNERAL HOME PA 200 S. HARRISON ST EASTON, MD 21601

Physician /Medical Examiner

23a. Pert I. Enter the diseese, or complicetions thet caused the deeth. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heart failure. List only one cause on eech line.

Approximete Interve! Between Onset end Deeth

Immedete Ceuse (Finel diseese or condition resulting in deeth)
a. Alzheimer's dementia
Due to (or es e consequenca of):

Sequentially list conditions, if any, leeding to immedete cause. Enter Underlying Ceuse (Diseese or Injury thet initieted events resulting in deeth) Lest
b.
Due to (or es e consequenca of):
c.
Due to (or es e consequenca of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
Atherosclerosis
Cerebrovascular accident
Aortic stenosis

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [X] Probably 4 [ ] Unknown

24e. Wes en eutopsy performed? 1 [ ] Yes 2 [X] No
24b. Were eutopsy findings eveilable prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Wes case referred to medical exeminer? 1 [ ] Yes 2 [X] No
26. Piece of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [X] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)
27. Manner of Deeth: [X] 1 Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigetion 6 [ ] Could not be determined
28e. Dete of Injury (Month, Dey Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Piece of Injury - At home, farm, street, fectory, office building, etc. (Specify)
28f. Locetion (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): [X] 1 **Certifying Physician**: To the best of my knowledge, deeth occurred et the time, date end placa, end due to the cause(s) end menner es stated. 2 [ ] **Medical Examiner**: On the basis of exeminetion and/or investigation, in my opinion, death occurred el the time, date end piece, end due to the cause(s) end menner stated.
29b. Signeture end fitie of certifier: Michael D. Crowley MD
29c. License number: D25933
29d. Date signed (Month, Dey, Year): 3-17-01

30. Neme end eddress of person who completed cause of deeth (Item 23e) (Type, Print): MICHAEL D. CROWLEY M.D. 508 IDLEWILD AVE EASTON, MD 21601

State Registrar

31. Dete filed (Month, Dey, Year): MAR 19 2001
32. Registrer's Signeture: Geneva D. Sparks

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print In Black Indellble Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Amended item#1,2,3(perMD),SRR,03-23-01,Talbot

Certificate of Death

Reg. No. 2001 10355

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): ~~Mary L. Wilson~~ MARY L. WILSON

2. Date of Death: Month ~~3~~ 3 Day ~~19~~ 19 Year ~~01~~ 01

3. Time of Death: ~~4:45~~ 4:45AM

4a. Facility Name (If not institution, give street end number): Mallard Bay

4b. City, Town, or Location of Death: Cambridge

4c. County of Death: Dorchester

Funeral Director

5. Social Security Number: 218-20-3281

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 72 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Aug.18,1928

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Dorchester

10c. City, Town or Location: Cambridge

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 520 Glenburn Ave.

10f. Zip Code: 21613

10g. Citizen of What Country? USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 5 College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Housewife

16b. Kind of Business/Industry: Own home

17. Father's Name (First, Middle, Last): Oscar Leatherberry

18. Mother's Name (First, Middle, Maiden Surname): Lula Unknown

19a. Informant's Name/Relationship (Type, Print): Blanche E. Butler /Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 121 South Lucust Street, Easton,Maryland 21601

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Paradise Cemetery

Date: 3/24/2001

20c. Location - City or Town, State: Trappe,Maryland

21. Signature of Funeral Service Licensee: John A. Prince

22. Name and Address of Facility: Bennie Smith Funeral Home 426 Dover Street, Easton,Maryland 21601

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Multiple Cerebro Vascular Accidents	10 yrs
Due to (or as a consequence of):	b. Generalized Debilitation	10 yrs
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	Due to (or as a consequence of): c.	
	Due to (or as a consequence of): d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Michael Fralich MD

29c. License number: D26388

29d. Date signed (Month, Day, Year): March 20, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Michael Fralich MD 302 Collins Ave Hurlock Md 21643

State Registrar

31. Date filed (Month, Day, Year): MAR 23 2001

32. Registrar's Signature: Geneva G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than 'natural', or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 10356

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Harriet Gray Watrous
2. Date of Death: Month March Day 19 Year 2001
3. Time of Death: 0805
4a. Facility Name (If not institution, give street and number): 211 Crestview Drive
4b. City, Town, or Location of Death: Thurmont
4c. County of Death: Frederick

Funeral Director

5. Social Security Number: 111-01-7147
6. Sex: 1☐ M 2☒ F
7. Age (in yrs. last birthday): 94 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Jan. 6, 1907
9. Birthplace (State or Foreign Country): New York

Usual Residence of Decedent

10a. State: Maryland
10b. County: Frederick
10c. City, Town or Location: Thurmont
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 211 Crestview Drive
10f. Zip Code: 21788
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Evar in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yas, specify Cuban, Mexican, Puarto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest greda completed): Elementary/Secondary (0-12) / College (1-4or 5+): 3 Years +
16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker
16b. Kind of Business/Industry: None

17. Father's Name (First, Middle, Last): Frederick Gray
18. Mother's Name (First, Middle, Maiden Surneme): Mabel Nelson

19a. Informant's Name/Ralationship (Type, Pnint): Helen W. Flanagan (Daughter)
19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code): 25 Flanagan Road Thurmont, Md. 21788

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, cremetory or other piece): Smithsburg Crematory
Date: 3/20/01
20c. Location - City or Town, State: Smithsburg, Md.

21. Signature of Funeral Service Licensee: Robert E. Dailey
22. Name and Address of Facility: ROBERT E. DDAILEY & SON FUNERAL HOMES, P.A. 615 E. MAIN STREET, THURMONT, MD. 21788

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Ceuse (Final disease or condition resulting in death)
a. Exposure — Immediate

Due to (or as a consequence of):
b. Left Hip Fracture — hours

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in death) Last
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Ware autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☒ Yes 2☐ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Manner of Death: 1☐ Natural 2☒ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined
28a. Date of Injury (Month, Dey Year): March 18, 2001
28b. Time of Injury: 3:00 P M
28c. Injury at Work? 1☐ Yes 2☒ No
28d. Describe how injury occurred: wandered in yard and fell.
28e. Piece of Injury - At home, ferm, street, fectory, office building, etc. (Specify): home
28f. Location (Street and Number or Rural Route Number, City or Town, State): 211 Crestview Thurmont, MD

29e. Certifier (Check only one): 1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and placa, and due to the cause(s) end manner as stated. 2☒ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Andrew Zarick
29c. License number: D35164
29d. Date signed (Month, Day, Year): March 19, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Andrew Zarick, Jr. M.D. 1080 W. Patrick St. Frederick, Md. 21703

State Registrar

31. Dete filed (Month, Day, Year): MAR 20 2001
32. Registrar's Signature: Geneva B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 10357

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Loretta J. Zickefoose

2. Date of Death — Month: March Day: 21 Year: 2001

3. Time of Death: 4:00 A.M

4a. Facility Name (If not institution, give street and number): 10 William Drive

4b. City, Town, or Location of Death: Thurmont

4c. County of Death: Frederick

Funeral Director

5. Social Security Number: 378-28-6865

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 69 Yrs.

If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Feb. 27, 1932

9. Birthplace (State or Foreign Country): New York

Usual Residence of Decedent

10a. State: Maryland

10b. County: Frederick

10c. City, Town or Location: Thurmont

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 10 William Drive

10f. Zip Code: 21788

10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: white

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Bookkeeper

16b. Kind of Business/Industry: Concrete Pike

17. Father's Name (First, Middle, Last): Lloyd J. Phillips

18. Mother's Name (First, Middle, Maiden Surname): Nellie Hall

19a. Informant's Name/Relationship (Type, Print): Doug Zickefoose / son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 10 William Drive, Thurmont, MD 21788

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Resthaven Mem. Gardens Date: 3/23/01

20c. Location - City or Town, State: Frederick, Maryland

21. Signature of Funeral Service Licensee: Jacqueline Hill

22. Name and Address of Facility: Stauffer Funeral Homes, P.A. 104 East Main St., Thurmont, MD 21788

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death): a. Lung Cancer — Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Approximate Interval Between Onset and Death: 7 wks

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1☐ Yes 2☒ No 9☐ Unknown

23c. If yes, outcome of pregnancy: 1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) 9☐ Unknown

23d. Date of delivery — Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☒ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

28. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature] MD

29c. License number: D 27109

29d. Date signed (Month, Day, Year): 3/24/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Lloyd H Halvorson MD, 1475 Taney Ave, Frederick Md 21702

State Registrar

31. Date filed (Month, Day, Year): MAR 23 2001

32. Registrar's Signature: Denise B Sparks

To be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 10358

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: MARTHA ANN ARMITAGE
2. Date of Death — Month: April Day: 02 Year: 2001
3. Time of Death: 5:45 PM
4a. Facility Name *(If not institution, give street and number)*: St. Elizabeth Rehabilitation & Nursing Center
4b. City, Town, or Location of Death: Baltimore
4c. County of Death:

Funeral Director

5. Social Security Number: 354-12-0732
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 96 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: 04-21-1904
9. Birthplace *(State or Foreign Country)*: Illinois

Usual Residence of Decedent

10a. State: MD.
10b. County:
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 3320 Benson Avenue
10f. Zip Code: 21227
10g. Citizen of What Country?: USA

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No — If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): — College (1-4or 5+): 4
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Middle school teacher
16b. Kind of Business/Industry: Education

17. Father's Name *(First, Middle, Last)*: Lewis Armitage
18. Mother's Name *(First, Middle, Maiden Surname)*: Ellen Ward

19a. Informant's Name/Relationship *(Type, Print)*: Mary Ellen Bean - niece
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 14 S. Beechwood Avenue, Catonsville, MD. 21228

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Balt/Wash/Crematory — Date: 04-04-2001
20c. Location - City or Town, State: Laurel, MD.
21. Signature of Funeral Service Licensee: ▶ Sandra L Lemmer
22. Name and Address of Facility: Witzke Funeral Home/Catonsville, 1630 Edmondson Ave., Catonsville, MD. 21228

Physician /Medical Examiner

23a. Part I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Alzheimer's Disease — years

Due to (or as a consequence of):
b. Depression — years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
c. Anorexia — months

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death *(Check only one)* — Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☒ Nursing Home 5☐ Residence 6☐ Other *(Specify)*
27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury *(Month, Day, Year)*
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28a. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: ▶ MD
29c. License number: D0055391
29d. Date signed *(Month, Day, Year)*: April 03, 2001
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): MING YI 210 Business Center Drive, Reisterstown, Maryland 21136

State Registrar

31. Date filed *(Month, Day, Year)*: APR 05 2001
32. Registrar's Signature: ▶ D Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

1- For State Registrar

Reg. No. 2001 10359

MC

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month / Day / Year	3. Time of Death
Vahid Aligholizad Anhary	04 / 02 / 2001	8.05 P.M.

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Howard County General Hospital	Columbia	Howard

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
215-11-1951	1[X] M 2[ ] F	39 Yrs.			11-18-1961	Iran

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	Howard	Columbia	1[ ] Yes 2[X] No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
9239 Hourglass Place	21045	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1[ ] Never Married 2[ ] Married 3[ ] Widowed 4[X] Divorced	1[ ] Yes 2[X] No If Yes, Give Year or Dates:	1[ ] Yes 2[X] No Specify:	Specify: Asian

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12	4	Engineer	Motorola

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Mohammad Aligholizad Anhary	Irandokht Amry

19a. Informent's Neme/Relationship (Type, Print)	19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Irandokht Amry-mother	9239 Hourglass Place,Columbia,Maryland 21045

20a. Method of Disposition	20b. Place of Disposition (Neme of cemetery, cremetory or other piece)	Dete	20c. Location - City or Town, Stete
1[X] Buriel 2[ ] Cremation 3[ ] Removal from State 4[ ] Donetion 5[ ] Other (Specify)	Maryland NationalCem.	04-05-2001	Laurel,Maryland

21. Signeture of Funeral Service Licensee	22. Name and Address of Facility
Nanda L Lemmer	Fleck Funeral Home Inc. 7601 Sandy Spring Road,Laurel,MD 20707

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other trauma event, the Medical Examiner must be notified at once.**

Physician /Medical Examiner

23e. Part I. Enter the disease, or complicetions that caused the death. Do not enter the mode of dying, such es cardiac or respiratory errest, shock, or heert failure. List only one cause on each line.

		Approximete Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. RENAL FAILURE	2 weeks
Sequentially list conditions, if any, leeding to immediete cause. Enter Underlying Cause (Diseasa or injury that initieted events resulting in death) Last	Due to (or as e consequence of): b. HEPATIC FAILURE	1 year
	Due to (or es e consequence of): c. METASTATIC NEURDENDOCRINE CANCER	3 years
	Due to (or es e consequence of): d.	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Dete of delivery Month / Dey / Year
1[ ] Yes 2[ ] No 9[ ] Unknown	1[ ] Live birth 2[ ] Fetel deeth 3[ ] Ectopic pregnancy 4[ ] Pregnent at time of death 5[ ] Other (specify) 9[ ] Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

MALNUTRITION.

23e. Did tobecco use contribute to the cause of deeth? 1[ ] Yes 2[X] No 3[ ] Probebly 4[ ] Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of deeth?
1[ ] Yes 2[X] No	1[ ] Yes 2[ ] No

25. Wes case referred to medical examiner?	26. Place of Death (Check only one)	
1[ ] Yes 2[X] No	Hospital: 1[X] Inpatient 2[ ] ER/Outpatient 3[ ] DOA	Other: 4[ ] Nursing Home 5[ ] Residence 6[ ] Other (Specify)

27. Menner of Deeth	28a. Dete of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1[X] Netural 2[ ] Accident 3[ ] Suicida 4[ ] Homicide 5[ ] Pending investigetion 6[ ] Could not be determined		M	1[ ] Yes 2[ ] No	
	28e. Place of Injury - At home, farm, street, fectory, offica building, etc. (Specify)			28f. Location (Street and Number or Rurel Route Number, City or Town, Stete)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one)
1[X] **Certifying Physician:** To the best of my knowledge, death occurred et the time, date and place, and due to the cause(s) end manner es steted.
2[ ] **Medicat Examiner:** On the basis of examinetion end/or investigation, in my opinion, death occurred et the time, date end place, end due to the cause(s) and menner stated.

29b. Signature end title of certifier	29c. Licanse number	29d. Date signed (Month, Day, Yeer)
MShaukat MD	D31331	APRIL 3rd 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
MONA SHAUKAT 10802 HICKORY RIDGE ROAD. COLUMBIA MD 21044

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

State Registrar

31. Date filed (Month, Dey, Year)	32. Registrar's Signature
APR 05 2001	Jeneva G Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

1- For State Registrar

Reg. No. 2001 10360

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
Ora F. Austin	April 2, 2001	11:00 a^M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
101 Center Place Apt. #219	Dundalk	Baltimore

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
214-24-1759	1☐M 2☒F	75 Yrs.			Aug. 30, 1925	Virginia

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Baltimore	Dundalk	1☐Yes 2☒No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
101 Center Place Apt. #219	21222	United States

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐Never Married 2☐Married XX 3☐Widowed 4☐Divorced	1☐Yes 2☒No If Yes, Give Year or Dates:	1☐Yes 2☒No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
8 years		Waitress	Restaurant

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Clarence A. Austin	Emma F. Garrison

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
James King (Son)	1943 Jasmine Road Dundalk, Maryland 21222

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	Meadowridge Mem. Pk.	4/6/01	Dorsey, Maryland

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
Eugene E. Ruck	Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Avenue Dundalk, Maryland 21222

Physician /Medical Examiner

Medical Certification; To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Stroke	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of): b. ASCVD	
	Due to (or as a consequence of): c. Hyperlipidemia	
	Due to (or as a consequence of): d.	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery
1☐Yes 2☒No 9☐Unknown	1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown	Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?	24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☒Yes 2☐No 3☐Probably 4☐Unknown	1☐Yes 2☒No	1☐Yes 2☐No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐Yes 2☒No	Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA	Other: 4☐Nursing Home 5☒Residence 8☐Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☐Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined		M	1☐Yes 2☐No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of Certifier	29c. License number	29d. Date signed (Month, Day, Year)
D. MacDonald	D15408	4/3/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) D. MacDonald 2801 Hudson St 21224

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
APR 05 2001	Geneva G Sparks

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 10361

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): NELLIE ELIZABETH BALL
2. Date of Death (Month, Day, Year): APR 4 2001
3. Time of Death: 11:30 AM
4a. Facility Name (If not institution, give street and number): 330 N. GRANTLEY STREET
4b. City, Town, or Location of Death: BALTIMORE
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 216-12-2032
6. Sex: 1☐ M 2☑ F
7. Age (In yrs. last birthday): 92 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Nov. 16, 1908
9. Birthplace (State or Foreign Country): VIRGINIA

Usual Residence of Decedent

10a. State: MARYLAND
10b. County: N/A
10c. City, Town or Location: BALTIMORE
10d. Inside City Limits: 1☑ Yes 2☐ No
10e. Street and Number: 330 N. GRANTLEY ST.
10f. Zip Code: 21229
10g. Citizen of What Country? U S A

11. Marital Status: 1☐ Never Married 2☐ Married 3☑ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☑ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☑ No Specify:
14. Race - American Indian, Black, White, etc. Specify: BLACK

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 7 College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): DOMESTIC
16b. Kind of Business/Industry: PRIVATE FAMILY

17. Father's Name (First, Middle, Last): HENRY GASKINS
18. Mother's Name (First, Middle, Maiden Surname): KATHERINE NEWTON

19a. Informant's Name, Relationship (Type, Print): LEE ESTHER STEWART
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 330 N. GRANTLEY ST. BALTO. MD. 21229

20a. Method of Disposition: 1☑ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): WOODLAWN CEMETERY Date: 4/9/2001
20c. Location - City or Town, State: BALTO. MD.

21. Signature of Funeral Service Licensee: ▶ Blonia Adams Jones
22. Name and Address of Facility: MARSHALL-JONES JR. F.H. P.A. 401 Edmondson Ave. BALTO. MD 21229

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. (Approximate Interval Between Onset and Death)

Immediate Cause (Final disease or condition resulting in death): a. Dementia.

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: hypertension, Arthritis
Peripheral Vascular disease

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☑ No

Medical Certification: To Be Completed by Physician/Medical Examiner

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☑ Residence 6☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ MD
29c. License number: D31322
29d. Date signed (Month, Day, Year): 4/5/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Pradeep GARG MD 716 Maiden Choice Ln, BALTO, Md 21228

State Registrar

31. Date filed (Month, Day, Year): APR 05 2001
32. Registrar's Signature: ▶ Lenore B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

01-1840-005
mnmr
Mary S. Brooks

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar AMEND ITEM 23a,ptII,27 per ME G794 041801 SS

Certificate of Death

Reg. No. 2001 10362

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Mary Sonia Brooks
2. Date of Death (Month, Day, Year): April 02, 2001
3. Time of Death: 805 a M
4a. Facility Name (If not institution, give street and number): 8057 Park Haven Road
4b. City, Town, or Location of Death: Dundalk
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 220-38-6189
6. Sex: 1☐M 2☒F
7. Age (In yrs. last birthday): 60 Yrs. (If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.)
8. Date of Birth (Month, Day, Year): Jan. 8,1941
9. Birthplace (State or Foreign Country): Virginia

Usual Residence of Decedent

10a. State: Maryland
10b. County: Baltimore
10c. City, Town or Location: Dundalk
10d. Inside City Limits: 1☐Yes 2☒No
10e. Street and Number: 8057 Park Haven Road
10f. Zip Code: 21222
10g. Citizen of What Country? United States

11. Marital Status: 1☐Never Married 2☒Married 3☐Widowed 4☐Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐Yes 2☒No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 8 Years; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker
18b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): Ed Clark
18. Mother's Name (First, Middle, Maiden Surname): Betty Garrison

19a. Informant's Name/Relationship (Type, Print): Mr. Venton T. Brooks (Husband)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 8057 Park Haven Road Dundalk, Maryland 21222

20a. Method of Disposition: 1☐Burial 2☒Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Hilltop Service Corp. Date: 4/5/2001
20c. Location - City or Town, State: Towson, Maryland

21. Signature of Funeral Service Licensee: Stephanie Massey
22. Name and Address of Facility: Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. (Approximate Interval Between Onset and Death)

Immediate Cause (Final disease or condition resulting in death):
a. ATHEROSCLEROTIC CARDIOVASCULAR DISEASE
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d.

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐Yes 2☐No 9☒Unknown
23c. If yes, outcome of pregnancy: 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown
23d. Date of delivery (Month, Day, Year)

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
DIABETES MELLITUS, CHRONIC OBSTRUCTIVE PULMONARY DISEASE

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☑Unknown
24a. Was an autopsy performed? 1☑Yes 2☐No
24b. Were autopsy findings available prior to completion of cause of death? 1☑Yes 2☐No

25. Was case referred to medical examiner? 1☒Yes 2☐No
28. Place of Death (Check only one): Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☐Residence 6☒Other (Specify) at scene

27. Manner of Death: 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐Yes 2☐No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☐ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☒ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: J Pestaner M.D.
29c. License number: O.C.M.E.
29d. Date signed (Month, Day, Year): April 04, 2001
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Joseph Pestaner 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date Filed (Month, Day, Year): APR 05 2001
32. Registrar's Signature: Denise G Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23e or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification; To Be Completed by Physician/Medical Examiner

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 10363

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): GEORGE BUDNY
2. Date of Death: Month APRIL Day 01 Year 2001
3. Time of Death: 6:20 AM
4a. Facility Name (If not institution, give street and number): HARBOR HOSPITAL CENTER
4b. City, Town, or Location of Death: BALTIMORE
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 217-24-0344
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 72 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): April 18, 1928
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: N/A
10c. City, Town or Location: Baltimore City
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 1602 East Clement Street
10f. Zip Code: 21230
10g. Citizen of What Country? United States

11. Marital Status: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Yeer or Dates: Army 46-48
13. Wes Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White
15. Decedent's Education (Specify only highest grade completed): Elementery/Secondary (0-12): 12 | College (1-4or 5+): 0
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Longshoreman
16b. Kind of Business/Industry: Shipping
17. Father's Neme (First, Middle, Last): Albert Budny
18. Mother's Name (First, Middle, Maiden Surname): Mary Fuka
19a. Informent's Neme/Relationship (Type, Print): Lillian A. Taylor / Sister
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1450 Towson Street, Baltimore Maryland 21230
20a. Method of Disposition: 1 [X] Buriel 2 [ ] Cremetion 3 [ ] Removal from State 4 [ ] Donetion 5 [ ] Other (Specify)
20b. Piece of Disposition (Neme of cemetery, crematory or other place): Holy Cross Cemetery
Date: April 4, 2001
20c. Location - City or Town, Stata: Baltimore Maryland
21. Signeture of Funerel Service Licensee: Victor P. Doda, Jr.
22. Name end Address of Fecility: Charles L. Stevens Funeral Home, Inc. 1501 East Fort Avenue, Baltimore Maryland 21230

Physician /Medical Examiner

23a. Part1. Enter the diseese, or complicetions that caused the death. Do not enter the mode of dying, such as cerdiac or respiretory arrest, shock, or heart feilure. List only one cause en each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final diseese or condition resulting in deeth) e.	SEPSIS	TWO WEEKS
Due to (or as e consequence of):		
b.	PNEUMONIA	TWO WEEKS
Sequentially list conditions, if any, leading to immediete cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last — Due to (or as a consequence of): c.	RENAL FAILURE	TWO WEEKS
d.	MYOCARDIAL INFARCTION	TWO WEEKS

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

DIABETES MELLITUS

ATRIAL FIBRILLATION.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [/] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [/] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [/] No

25. Wes case referred to medical examiner? 1 [ ] Yes 2 [/] No

26. Piece of Deeth (Check only one): Hospitel: 1 [/] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Menner of Death: 1 [/] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Piece of Injury - At home, farm, street, fectory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29e. Certifier (Check only one): 1 [/] **Certifying Physician**: To the best of my knowledge, deeth occurred et the time, date and place, and due to the cause(s) and menner as stated. 2 [ ] **Medical Examiner**: On the basis of examinetion and/or investigetion, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and menner steted.

29b. Signeture end title of certifier: Sumeet Sawhney, MD.
29c. License number: P-14121
29d. Date signed (Month, Day, Year): APRIL 01 2001.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): SUMEET SAWHNEY HARBOR HOSPITAL CENTER.

State Registrar

31. Dete filed (Month, Day, Year): APR 05 2001
32. Registrer's Signeture: Geneva G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

AMEND ITEM: #8 PER F.H. G794 4-11-01 WR.

Certificate of Death

Reg. No. 2001 10364

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): John E. Bohrer
2. Date of Death (Month, Day, Year): April 2, 2001
3. Time of Death: 8:20pm
4a. Facility Name (If not institution, give street and number): 1105 William Street
4b. City, Town, or Location of Death: Baltimore City
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 236-42-0414
6. Sex: 1☒ M 2☐ F
7. Age (In yrs. last birthday): 71 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Data of Birth (Month, Day, Year): ~~June 16~~, 1929
9. Birthplace (State or Foreign Country): WV

Usual Residence of Decedent

10a. State: MD
10b. County: N/A
10c. City, Town or Location: Baltimore City
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 1105 William Street
10f. Zip Code: 21230
10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? ☒Yes 2☐ No If Yes, Give Year or Dates: Army 48-52
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yas, specify Cuban, Maxican, Puerto Rican, etc.): 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc.: Specify: White

15. Decedent's Education (Specify only highest grade completed): Elamantary/Secondary (0-12): 6; College (1-4or 5+): 0
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Stationary Engineer
16b. Kind of Business/Industry: Manufacturing

17. Father's Name (First, Middle, Last): Earl Blaine Otis Bohrer
18. Mother's Name (First, Middle, Maiden Surname): Laura Mae McDonald

19a. Informant's Name/Relationship (Type, Print): Lula S. Bohrer / Wife
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1105 William Street, Baltimore MD 21230

20a. Method of Disposition: 1☐ Burial 2☐ Cremation 3☒ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Harmony cemetery
Date: April 7,2001
20c. Location - City or Town, State: West Virginia

21. Signature of Funeral Service Licensee: Victor P. Doda, Jr.
22. Name and Address of Facility: Charles L. Stevens Funeral Home, Inc. 1501 East Fort Avenue, Baltimore Maryland 21230

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Right Heart Failure — Days
Due to (or as a consequence of):
b. Atrial Septal Defect — Years
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c. Pulmonary Hypertension — Years
Due to (or as a consequence of):
d. Massive Obesity — 50 Years

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Fungal Peritonitis
Diabetes Mellitus II
End Stage Renal Disease

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Paul D. Light MD
29c. License number: D17522
29d. Date signed (Month, Day, Year): April 4, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Paul D. Light, MD

State Registrar

31. Date filed (Month, Day, Year): APR 05 2001
32. Registrar's Signature: Geneva G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 10365

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Donald Deemer Bauman
2. Date of Death Month Day Year: April 2,2001
3. Time of Death: 11:05 AM
4a. Facility Name *(If not institution, give street and number)*: Stella Maris Hospice Center
4b. City, Town, or Location of Death: Towson
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 194 16 7182
6. Sex: 1☐M 2☐F — X
7. Age *(In yrs. last birthday)*: 77 Yrs. — If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: June 12,1923
9. Birthplace *(State or Foreign Country)*: Pennsylvania

Usual Residence of Decedent

10a. State: Maryland
10b. County: Baltimore
10c. City, Town or Location: Middle River
10d. Inside City Limits: 1☐Yes 2☐No — X
10e. Street and Number: 1821 Wilson Point Road
10f. Zip Code: 21220
10g. Citizen of What Country?: USA

11. Marital Status: 1☐Never Married 2☒Married 3☐Widowed 4☐Divorced
12. Wes Decedent Ever in U.S. Armed Forces? 1☐Yes 2☐No If Yes, Give Yeer or Dates: WW 2
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐Yes 2☒No *Specify:*
14. Rece - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12; College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use ratired)*: Supervisor
16b. Kind of Business/Industry: US Military

17. Father's Nama *(First, Middle, Last)*: Elwood Bauman
18. Mother's Neme *(First, Middle, Maiden Sumame)*: Gladys Deemer

19a. Informant's Name/Relationship *(Type, Print)*: Jean M. Bauman (wife)
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 1821 Wilson Point Road Middle River, Maryland 21220

20e. Method of Disposition: 1☒Burial 2☐Cremetion 3☐Removel from Stete 4☐Donation 5☐Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, cremetory or other place)*: Holly Hill Mem. Gardens — Date: 4/4/2001
20c. Location - City or Town, Stete: Baltimore Co.,Maryland

21. Signature of Funeral Service Licensee: [signature]
22. Name end Address of Facility: Bruzdzinski Funeral Home PA 1407 Old EAstern Avenue Essex, Maryland 21221

Physician /Medical Examiner

23a. Part I. Enter the disease, or complicetions that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. COLON CANCER
Due to (or as e consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
b.
Due to (or es e consequence of):
c.
Due to (or es a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contributs to the cause of death? 1☐Yes 2☐No 3☐Probably 4☒Unknown

24a. Was an autopsy performed? 1☐Yes 2☒No
24b. Were autopsy findings evailable prior to completion of cause of death? 1☐Yes 2☐No

25. Was case referred to medical examiner? 1☐Yes 2☒No
26. Place of Death *(Check only one)*: Hospitel: 1☐Inpatient 2☐ER/Outpatient 3☐DOA; Other: 4☐Nursing Home 5☐Residence 8☒Other *(Specify)* HOSPICE
27. Manner of Death: 1☒Netural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigetion 6☐Could not be determined
28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury M
28c. Injury at Work? 1☐Yes 2☐No
28d. Describe how injury occurred
28e. Pleca of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier *(Check only one)*: 1☒**Certifying Physician**: To the best of my knowledge, death occurred at the time, dete and plece, and due to the cause(s) and menner as stated. 2☐**Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end menner steted.

29b. Signature and title of certifier: [signature]
29c. License number: D43725
29d. Date signed *(Month, Day, Year)*: 4/2/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): DR. TARIQ MAHMOOD 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093

State Registrar

31. Date filed *(Month, Day, Year)*: APR 05 2001
32. Registrar's Signeture: [signature]

DHMH 16 Rev 6/95

ORIGINAL

To be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

APRIL 2, 2001 11:05 a.m.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Division of Vital Records, P.O. Box 68760,

DONALD BAUMAN

B-154

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 10366

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
SARAH E. BIBBINS	MARCH 27, 2001	7:45pm M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
14 S. BERNICE AVE.	BALTIMORE	N/A

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
213-36-1483	1☐M 2☒F	61 Yrs.			5-22-1939	MARYLAND

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD.	N/A	BALTIMORE	1☒Yes 2☐No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
14 S. BERNICE AVE.	21223	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐Never Married 2☐Married 3☒Widowed 4☐Divorced	1☐Yes 2☒No If Yes, Give Year or Dates:	1☐Yes 2☒No Specify:	Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
-12-	-0-	LABORATORY TECHNICIAN	CLINICAL LABORATORY

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
THOMAS A. GROSS	ESTELL MASON

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, Stete, Zip Code)
KEVIN BIBBINS(SON)	2 POOLSIDE COURT APT 18 CATONSVILLE, MARYLAND 21228

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, cremetory or other piece)	Date	20c. Location - City or Town, Stete
1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	GARRISON FOREST VETERANS	4-3-2001	OWINGS MILLS, MARYLAND

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ Martha D. Hibrew	PHILLIPS FUNERAL HOME, P.A. 1721-27 N. MONROE ST. BALTIMORE, MARYLAND 21217

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. RECTAL ADENOCARCINOMA	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of):	
	c. Due to (or as a consequence of):	
	d. Due to (or as a consequence of):	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month Day Year
1☐Yes 2☒No 9☐Unknown	1☐Live birth 2☐Fetel death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?	24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐Yes 2☐No 3☐Probably 4☒Unknown	1☐Yes 2☒No	1☐Yes 2☒No

25. Was case referred to medical examiner?	28. Place of Death (Check only one)	
1☐Yes 2☒No	Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA	Other: 4☐Nursing Home 5☒Residence 6☐Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Yeer)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined		M	1☐Yes 2☐No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rurel Route Number, City or Town, State)

Medical Certification; To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one)
1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as steted.
2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Dey, Year)
▶	D52294	4/4/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
COLIN OTTEY 301 ST. PAUL PLACE SUITE 715

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
APR 05 2001	▶ G Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified as soon as possible.

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 10367

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Physician /Medical Examiner

Funeral Director

To Be Completed by Funeral Director

1. Decedent's Name (First, Middle, Last)	2. Date of Death (Month, Day, Year)	3. Time of Death
CAROL COFIELD	APRIL 2, 2001	5:10 AM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
FUTURE CARE OF HOMEWOOD	BALTIMORE	N/A

5. Social Security Number	6. Sex (1 M 2 F)	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
216-42-9618	2 F	56 Yrs.			01-11-1945	MD

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	N/A	BALTIMORE	1 Yes 2 No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
5332 Beaufort	21215	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puarto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1 Never Married 2 Married 3 Widowed 4 Divorced	1 Yes 2 No If Yes, Give Year or Datas:	1 Yes 2 No Specify:	Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12		TECHNICIAN	ELECTRONICS

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
HOZELL BUSH	GLADYS COVINGTON

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
GLADYS BUSH, MOTHER	5119 QUEENSBURY AVE, BALTO. MD 21215

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, cremetory or other place)	Date	20c. Location - City or Town, State
1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)	KING MEMORIAL PARK	4-6-01	RANDALLSTOWN, MD

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ Willie E Howell Jr.	HOWELL FUNERAL HOME 4600 LIBERTY HGHTS AVE, BALTO. MD 21207

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failura. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. SEPSIS	2 WEEKS
Due to (or as a consequence of):	b. STAGE IV SACRAL DECUBITUS	4 MONTHS
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	Due to (or as a consequence of): c.	
	Due to (or as a consequence of): d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

INSULIN DEPENDANT DIABETES MELLITUS

ESSENTIAL HYPERTENSION

END STAGE RENAL DISEASE.

23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown

24a. Was an autopsy performed? 1 Yes 2 No

24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No

25. Was case referred to medical examiner? 1 Yes 2 No

26. Place of Death (Check only one)
Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA
Other: 4 Nursing Home 5 Residence 6 Other (Specify)

27. Manner of Death: 1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work? 1 Yes 2 No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1 **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ Komal K. Dang MD	D18362	4-2-2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
KOMAL K. DANG M.D. 3455, WILKENS AVE. SUITE 308. BALTO. MD 21229

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
APR 05 2001	▶ Barbara B. Sparks

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit case.

DHMH 16 Rev 6/95

ORIGINAL

01-1798-033
crn
Clayton B. Cox

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar AMEND ITEM 23a,27 per ME G795 053001 SS

Certificate of Death

Reg. No: 2001 10368

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month / Day / Year	3. Time of Death
Clayton B. Cox	April 02 2001	4:37 P M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Comfort Inn, Room #218 4500 Crain Highway	Bowie	Prince George's

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
UNK.	1 X M 2 ☐ F	49 Yrs.			DEC 15, 1951	Illinois

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Prince George's	Bowie	1 ☐ Yes 2 X No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
Comfort Inn, Room #218 4500 Crain Highway	20716	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 X Divorced	1 ☐ Yes 2 X No If Yes, Give Year or Dates:	1 ☐ Yes 2 X No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	18b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
	4	Video Producer	Video Production

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Buford O. Cox	Dolores M. Egebrecht

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Dolores M. Cox/Mother	5400 Vantage Point Rd. #404 Columbia, MD 21044

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place) / Date	20c. Location - City or Town, State
1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	Metro Crematory Inc. 4-4-01	Baltimore, MD

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
Edward A. Grezorchik	Cremation Society of MD, Inc. 299 Frederick Road Baltimore, MD 21228

Physician /Medical Examiner

Medical Certification; To Be Completed by Physician/Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory errest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. DILATED CARDIOMYOPATHY WITH RIGHT VENTRICULAR HYPERTROPHY

Sequentially list conditions, if any, leading to immediete cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as e consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pregnency 1 ☐ Live birth 2 ☐ Fetel death 3 ☐ Ectopic pregnancy 4 ☐ Pregnent et time of death 5 ☐ Other (specify) 9 ☐ Unknown	23d. Dete of delivery Month / Day / Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probebly 4 ☐ Unknown

24a. Was en autopsy performed? 1 X Yes 2 ☐ No	24b. Were autopsy findings available prior to completion of cause of death? 1 X Yes 2 ☐ No

25. Wes case referred to medical examiner? 1 X Yes 2 ☐ No	26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 X Other (Specify) at scene

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury et Work?	28d. Describe how injury occurred
1 X Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigetion 6 ☐ Could not be determined		M	1 ☐ Yes 2 ☐ No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Locetion (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1 ☐ **Certifying Physician**: To the best of my knowledge, death occurred et the time, date and place, end due to the cause(s) and menner as stated.
2 X **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at tha time, date and piece, and due to the ceuse(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
J. Laron Locke M.D.	O.C.M.E.	April 03, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
J. Laron Locke M.D. 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Dete filed (Month, Day, Year)	32. Registrar's Signature
APR 05 2001	

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than 'natural', or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 10369

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Henry Milton Corbin Sr.

2. Date of Death — Month: April Day: 3 Year: 2001

3. Time of Death: 11:05 AM

4a. Facility Name *(If not institution, give street and number)*: Levindale Geriatric Center

4b. City, Town, or Location of Death: Baltimore city

4c. County of Death:

Funeral Director

5. Social Security Number: 217-18-0787

6. Sex: 1 [X] M 2 [ ] F

7. Age *(In yrs. last birthday)*: 77 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: April 2, 1924

9. Birthplace *(State or Foreign Country)*: Baltimore, Md.

Usual Residence of Decedent

10a. State: Md.

10b. County: Carroll

10c. City, Town or Location: Manchester

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 3306 Meadowview Dr.

10f. Zip Code: 21102

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No — If Yes, Give Yeer or Dates: W.W.II

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Educetion *(Specify only highest grade completed)* — Elementary/Secondary (0-12): 10 — College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Truck Driver

16b. Kind of Business/Industry: Wilson Freight

17. Father's Name *(First, Middle, Last)*: W. Edwin Corbin

18. Mother's Name *(First, Middle, Meiden Surname)*: Amelia Julia Reuwer

19a. Informant's Name/Relationship *(Type, Print)*: Elsie L. Corbin - wife

19b. Mailing Address *(Street end Number or Rurel Route Number, City or Town, State, Zip Code)*: 3306 Meadowview Dr. Manchester, Md. 21102

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*

20b. Place of Disposition *(Neme of cemetery, cremetory or other place)*: Evergreen Mem. Gardens — Date: April 6, 2001

20c. Location - City or Town, State: Finksburg, Md.

21. Signature of Funeral Service Licensee: J. Scott Eckhardt

22. Name and Address of Facility: Eckhardt Funeral Chapel, P.A. 3296 Charmil Dr. Manchester, Md. 21102

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

Immediate Ceuse (Finel disease or condition resulting in death)
a. Atherosclerotic Coronary Artery Disease

Due to (or as a consequence of):
b. Diabetes Mellitus

Sequentially list conditions, if sny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c.

Due fo (or as a consequence of):
d.

Part II. **Other significant conditfons** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [X] Probably 4 [ ] Unknown

24a. Was en autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior fo completion of ceuse of death? 1 [ ] Yes 2 [X] No

25. Wes cese referred to medicel examiner? 1 [ ] Yes 2 [X] No

26. Place of Death *(Check only one)* — Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other *(Specify)*

27. Manner of Death: 1 [X] Netural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Piece of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street end Number or Rural Route Number, City or Town, Stete)*

29a. Certifier *(Check only one)*: 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred et fhe fime, date and place, and due fo the ceuse(s) and manner stated.

29b. Signature and title of certifier: Deborah S. Oestheimer MD

29c. License number: D23767

29d. Date signed *(Month, Dey, Year)*: April 3, 2001

30. Neme and address of person who completed ceuse of death (Item 23a) (Type, Print): Debra S. Oestheimer 2934 U. Belvedere Ave, Balto, Md 21215

State Registrar

31. Date filed *(Month, Day, Year)*: APR 11 5 2001

32. Registrar's Signature:

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 10370

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month / Day / Year	3. Time of Death
THOMAS G. CASTAGNA	APRIL 3 2001	7:10 P M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
306 S. EXETER ST	BALTIMORE	N/A

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
213-54-4012	1☒M 2☐F	44 Yrs.			Sept 10 1956	MD.

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	N/A	BALTIMORE	1☒Yes 2☐No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
306 S. EXETER ST	21202	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐Never Married 2☒Married 3☐Widowed 4☐Divorced	1☐Yes 2☒No If Yes, Give Year or Dates:	1☐Yes 2☒No Specify:	Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)	CONSTRUCTION LABOR	BUILDING CONSTRUCTION
12	NONE		

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
PIETRO CASTAGNA	CONCETTA SERCI

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
THERESA CASTAGNA (SISTER)	220 S. BOULDIN ST. BALTO. MD. 21224

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☐Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☒Other (Specify) ENTOMBMENT	LORRAINE MAUSOLEUM	4/7/01	BALTO. MD.

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ [signature]	DELLA NOCE & SONS FUNERAL HOME 322 S. HIGH ST. BALTO. MD. 21202

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. METASTATIC LUNG CANCER — 8 MONTH

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1☐Yes 2☐No 9☐Unknown	23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown	23d. Date of delivery Month / Day / Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

CHRONIC RENAL FAILURE

23e. Did tobacco use contribute to the cause of death? 1☒Yes 2☐No 3☐Probably 4☐Unknown

24a. Was an autopsy performed? 1☐Yes 2☒No	24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☒No

25. Was case referred to medical examiner? 1☐Yes 2☒No	26. Place of Death (Check only one) Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☒Residence 6☐Other (Specify)

27. Manner of Death 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 8☐Could not be determined	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? 1☐Yes 2☐No	28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one)
1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ M. Puntell, Staff Physician	D19714	4/4/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
M. Puntell JHBMC 4940 IZAAK WALTON AVE, BALTIMORE MD 21224

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
APR 05 2001	▶ [signature]

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 10371

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)			2. Date of Death Month Day Year	3. Time of Death
ZULA	MAE	COPPADGE	APRIL 3, 2001	4:50 A

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
GENESIS ELDER CARE HAMMOND'S LANE	BROOKLYN PARK	ANNE ARUNDEL

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
169-20-6566	1☐ M 2☒ F	96 Yrs.			JUNE 6,1904	OK

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MARYLAND	ANNE ARUNDEL	GLEN BURNIE	1☐ Yes 2☒ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
6519 PAMPANO DRIVE	21061	U.S.A.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced	1☐ Yes 2☒ No If Yes, Give Year or Dates:	1☐ Yes 2☒ No Specify:	Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementery/Secondery (0-12)	College (1-4or 5+)		
6		SALES	RETAIL

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
ISRAEL GARRETT	SARAH STIDHAM

19a. Informent's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
MR. ROY COPPADGE (SON)	6519 PAMPANO DRIVE, GLEN BURNIE, MARYLAND 21060

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)	MEMORIAL PARK	4/9/2001	BARTLESVILLE, OK

21. Signature of Funeral Service Licensee ▶ Mar 7 05 Anne Sparks

22. Name and Address of Facility SINGLETON FUNERAL HOME, P.A., 1 SECOND AVENUE, S.W.,GLEN BURNIE, MD. 21061

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiretory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Cerebro vascular Accident	1 year
	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Coronary Artery Disease	10 years
	Due to (or as a consequence of):	
	c.	
	Due to (or as a consequence of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☒ Probably 4☐ Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐ Yes 2☒ No	1☐ Yes 2☐ No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐ Yes 2☒ No	Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA	Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒ Neturai 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined		M	1☐ Yes 2☐ No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29e. Certifier (Check only one) 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ MD	D53462	4/3/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Jude Muneses MD 7845 Oakwood Road Glen Burnie, MD 21061

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
APR 0 5 2001	▶ Geneva G Sparks

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than 'natural', or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Coppadge, 2

01-1778-510
mnmr
Richard Allen Coleman

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 10372

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)			2. Date of Death Month Day Year	3. Time of Death
RICHARD	ALAN	COLEMAN	April 01, 2001	1200 pM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
116 North Pace Street	Baltimore	N/A

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
218-58-7731	1☒M 2☐F	49 Yrs.			FEB 10, 1952	MARYLAND

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MARYLAND	N/A	BALTIMORE CITY	1☒Yes 2☐No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
2861 MULBERRY STREET	21223	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☒Never Married 2☐Married 3☐Widowed 4☐Divorced	1☐Yes 2☒No If Yes, Give Year or Dates:	1☐Yes 2☒No Specify:	Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12TH GRADE		MAINTENANCE MAN	HOSPITAL

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
ISADORE COLEMAN SR	UNKNOWN

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
SARAH McRAE (FOSTER CARE MOTHER)	2824 W. MULBERRY ST, BALTO, MD. 21223

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	MT. ZION CEMETERY	04-05-01	LANSDOWNE, MARYLAND

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
	JOSEPH H. BROWN JR. FUNERAL HOME 2140 N. FULTON AVE., BALTIMORE, MD. 21217

Physician /Medical Examiner

Medical Certification; To Be Completed by Physician/Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Cirrhosis of Liver	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of): b.	
	Due to (or as a consequence of): c.	
	Due to (or as a consequence of): d.	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month Day Year
1☐Yes 2☐No 9☐Unknown	1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Hypertensive Atherosclerotic Cardiovascular Disease

23e. Did tobacco use contribute to the cause of death?	24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐Yes 2☐No 3☐Probably 4☒Unknown	1☒Yes 2☐No	1☒Yes 2☐No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☒Yes 2☐No	Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA	Other: 4☐Nursing Home 5☐Residence 6☒Other (Specify) at scene

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined		M	1☐Yes 2☐No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☒ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
Theodore M. King MD	O.C.M.E.	April 02, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
THEODORE M. King 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
APR 05 2001	Steven G Adams

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

1- For State Registrar

Reg. No. 2001 10373

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month	Day	Year	3. Time of Death
Elaine A. Dann	April	2	2001	1600 PM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
St. Agnes Hospital	Baltimore	

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
220-05-5558	1☐M 2☒F	79 Yrs.			09/20/1921	Maryland

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	Baltimore	Baltimore	1☐Yes 2☒No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
405 Academy Road	21228	U.S.A.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐Never Married 2☒Married 3☐Widowed 4☐Divorced	1☐Yes 2☒No If Yes, Give Year or Dates:	1☐Yes 2☒No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12	0	Candy Store Clerk	Candy Store

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Elmer Bonsall	Marie McFarland

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Everett C. Dann-husband	405 Academy Road, Baltimore, Maryland, 21228

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☐Burial 2☐Cremation 3☐Removal from State 4☐Donetion 5☒Other (Specify) Mausoleum	Loudon Park Cemetery	04/06/2001	Baltimore, Maryland

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ Sandra L Lemmer	Witzke Funeral Home Of Catonsville 1630 Edmondson Avenue, Catonsville, MD., 21228

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Cerebrovascular accident	days
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of): b. atrial fibrillation	years
	Due to (or as a consequence of): c.	
	Due to (or as a consequence of): d.	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month / Day / Year
1☐Yes 2☒No 9☐Unknown	1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

infection (urinary tract)

23e. Did tobacco use contribute to the cause of death?	24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐Yes 2☐No 3☐Probably 4☒Unknown	1☐Yes 2☒No	1☐Yes 2☐No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐Yes 2☒No	Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA	Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined		M	1☐Yes 2☐No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification; To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one) 1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) end manner as stated. 2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, end due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ D M. Hardy, MD	#P14443	April 2, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Daniel M. Hardy St. Agnes Hospital

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
APR 05 2001	

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23e or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

NAME DANN, Elaine

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 10374

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): AUDREY DELUCA
2. Date of Death: Month APRIL Day 4th Year 2001
3. Time of Death: 10.25 PM.
4a. Facility Name (If not institution, give street and number): Northwest Hospital Center
4b. City, Town, or Location of Death: Randallstown
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 227-20-2733
6. Sex: 1☐M 2☒F
7. Age (In yrs. last birthday): 76 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Dec. 31, 1924
9. Birthplace (State or Foreign Country): Virginia

Usual Residence of Decedent

10a. State: Md.
10b. County: Baltimore
10c. City, Town or Location: Reisterstown
10d. Inside City Limits: 1☐Yes 2☒No
10e. Street and Number: 26 South Lake Way
10f. Zip Code: 21136
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐Never Married 2☐Married 3☒Widowed 4☐Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐Yes 2☒No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 11 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Consultant
16b. Kind of Business/Industry: Federal Government

17. Father's Name (First, Middle, Last): Spencer Hickman
18. Mother's Name (First, Middle, Maiden Surname): Elizabeth Killmon

19a. Informant's Name/Relationship (Type, Print): Spencer R. Hickman - Nephew
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2340 Amphibious Dr., Suite 125, Norfolk, Va, 23421

20a. Method of Disposition: 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donetion 5☐Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Woodlawn Cemetery | Date: April 7, 2001
20c. Location - City or Town, State: Woodlawn, Md.

21. Signature of Funeral Service Licensee: H.G. Eckhardt
22. Name and Address of Facility: Eckhardt Funeral Chapel 11605 Reisterstown Rd., Owings Mills, Md. 21117

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. BILATERAL PNEUMONIA	11 DAYS.
	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b.	
	Due to (or as a consequence of):	
	c.	
	Due to (or as a consequence of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☒Unknown

24a. Was an autopsy performed? 1☐Yes 2☒No
24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☒No

25. Was case referred to medical examiner? 1☐Yes 2☒No
26. Place of Death (Check only one): Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA | Other: 4☐Nursing Home 5☐Residence 8☐Other (Specify)

27. Manner of Death: 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined
28a. Date of Injury (Month, Day, Year)
28b. Time of Injury M
28c. Injury at Work? 1☐Yes 2☐No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated. 2☐**Medical Examiner:** On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ jogindra P mehta m.D
29c. License number: D0041410
29d. Date signed (Month, Day, Year): APRIL 4th, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): JOGINDER P MEHTA NORTHWEST HOSPITAL CENTER RANDALLSTOWN MD 21133

State Registrar

31. Date filed (Month, Day, Year): APR 05 2001
32. Registrar's Signature: ▶ Geneva G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

01-1850-510
crn
Norina M. D'Iorio

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 10375

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month	Day	Year	3. Time of Death
Norina M. D'Iorio	March	31	2001	12:02 A M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Johns Hopkins Hospital	Baltimore	N/A

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
206-36-6797	1☐M 2☒F	65 Yrs.			August 20, 1935	Pennsylvania

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
PA	Luzerne	Kingston	1☒Yes 2☐No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
258 James Street	18704	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐Never Married 2☐Married 3☐Widowed 4☒Divorced	1☐Yes 2☒No If Yes, Give Year or Dates:	1☐Yes 2☒No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
	5+	Physician	Medical

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Anthony D'Iorio	Deominia Adonizio

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Robert D'Iorio/Brother	258 James Street, Kingston, PA 18704

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	Denison Cemetery	04-05-2001	Swoyersville, PA

21. Signature of Funeral Service Licensee ▶ Joseph N. Zannino Jr.

22. Name and Address of Facility Joseph N. Zannino, JR. Funeral Home, 263 South Conkling St., Baltimore, MD 21224

Physician /Medical Examiner

Medical Certification; To Be Completed by Physician/Medical Examiner

23a. Part I: Enter the disease or complications that caused the death. Do not enter the mode of dying, such es cerdiac or respiratory errest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Exsanguination	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or es e consequence of): b. Puncture of Left Innominate Vein	
	Due to (or as e consequence of): c.	
	Due to (or as a consequence of): d.	

CERTIFICATION APPROVED BY MEDICAL EXAMINER

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnency	23d. Date of delivery Month / Day / Year
1☐Yes 2☒No 9☐Unknown	1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

24a. Was an autopsy performed? 1☒Yes 2☐No — Approval

24b. Were autopsy findings available prior to completion of cause of death? 1☒Yes 2☐No

25. Wes case referred to medical examiner? 1☒Yes 2☐No

28. Place of Death (Check only one): Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA; Other: 4☐Nursing Home 5☐Residence 8☐Other (Specify)

27. Manner of Death: 1☐Natural 2☒Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
03-30-2001	Unknown P M	1☐Yes 2☒No	Puncture of vessel during therapeutic procedure.

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify): Hospital

28f. Location (Street and Number or Rural Route Number, City or Town, State): 600 N. Wolfe Street Baltimore, Maryland

29a. Certifier (Check only one): 1☒Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to tha cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ Eric H. Powell	C 9313	April 05, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Eric Powell, M.D. 600 North Wolfe Street, Baltimore, Maryland 21287

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
APR 05 2001	▶ Donna G Sparks

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23e or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 10376

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Rose C. Davis

2. Date of Death: Month: April; Day: 3; Year: 2001

3. Time of Death: 11:30 PM

4a. Facility Name (If not institution, give street and number): St. Agnes Hospital

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: Baltimore City

Funeral Director

5. Social Security Number: 577-46-7781

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 70 Yrs.

If Under 1 Year: Months; Days. If Under 24 Hrs.: Hours; Min.

8. Date of Birth (Month, Day, Year): 09/17/1930

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: MD

10b. County: Anne Arundel

10c. City, Town or Location: Glen Burnie

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 712 Seagrove Road

10f. Zip Code: 21060

10g. Citizen of What Country? USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No. If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: WHite

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12); College (1-4or 5+): 5+

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Teacher

16b. Kind of Business/Industry: Education

17. Father's Name (First, Middle, Last): Samuel Joseph Culotta

18. Mother's Name (First, Middle, Maiden Surname): Roma Paccerelli

19a. Informant's Name/Relationship (Type, Print): Karen L. Davis/Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 712 Seagrove Road Glen Burnie, MD 21060

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Dispoaition (Name of cemetery, crematory or other place): Lorraine Park Cemetery

Date: 4/6/2001

20c. Location - City or Town, State: Baltimore, Maryland

21. Signature of Funeral Service Licensee: [signature]

22. Name and Address of Facility: Kirkley-Ruddick Funeral Home P.A. 421 Crain Highway S.E. Glen Burnie, MD 21061

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Sepsis — 1 week

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. End Stage Renal Disease — years

Due to (or as a consequence of):

c.

Due to (or as e consequence of):

d.

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1☐ Yes 2☒ No 9☐ Unknown

23c. If yes, outcome of pregnancy: 1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) 9☐ Unknown

23d. Date of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

28. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA. Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end menner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Hwan Young Yoo, MD

29c. License number: D0053514

29d. Date signed (Month, Day, Year): April 3, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Hwan Y. Yoo, MD. St. Agnes Hospital, Baltimore, MD 21229

State Registrar

31. Date filed (Month, Day, Year): APR 05 2001

32. Registrar's Signature: Donna G Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Rose C. Davis

NAME

10

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 10377

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: MELVIN LEE FENZEL
2. Date of Death Month Day Year: April 2, 2001
3. Time of Death: 1121
4a. Facility Name *(If not institution, give street and number)*: The Memorial Hospital
4b. City, Town, or Location of Death: Easton
4c. County of Death: Talbot

Funeral Director

5. Social Security Number: 219-26-8888
6. Sex: 1 [X] M 2 [ ] F
7. Age *(In yrs. last birthday)*: 62 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: OCT. 27, 1938
9. Birthplace *(State or Foreign Country)*: MARYLAND

Usual Residence of Decedent

10a. State: MARYLAND
10b. County: CAROLINE
10c. City, Town or Location: PRESTON
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 24272 MAR LYN DRIVE
10f. Zip Code: 21655
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 [ ] Yes 2 [XX] No Specify:
14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12; College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: MANAGER
16b. Kind of Business/Industry: INSURANCE COMPANY

17. Father's Name *(First, Middle, Last)*: MELVIN GEORGE FENZEL
18. Mother's Name *(First, Middle, Maiden Surname)*: MARY MARSH

19a. Informant's Name/Relationship *(Type, Print)*: MRS. ELAINE FENZEL (WIFE)
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 24272 MAR LYN DRIVE, PRESTON, MARYLAND 81655

20a. Method of Disposition: [XX] 1 Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: GLEN HAVEN MEMORIAL PARK
Date: 4/06/2001
20c. Location - City or Town, State: GLEN BURNIE, MARYLAND

21. Signature of Funeral Service Licensee: [signature] M00795
22. Name and Address of Facility: SINGLETON FUNERAL HOME, P.A., 1 SECOND AVENUE, S.W., GLEN BURNIE, MD. 21061

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death):
a. Acute Myocardial Infarction — Hour

Due to (or as a consequence of):
b. Coronary Artery Disease — Years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c. Diabetes Mellitus — Years

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No
26. Place of Death *(Check only one)*: Hospital: 1 [ ] Inpatient 2 [X] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other *(Specify)*

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined
28a. Date of Injury *(Month, Day, Year)*
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: [signature]
29c. License number: H0055154
29d. Date signed *(Month, Day, Year)*: 4-2-01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): JEFFREY R. BECK, M.D., MEMORIAL HOSPITAL AT EASTON, 219 S. WASHINGTON ST., EASTON, MD 21601

State Registrar

31. Date filed *(Month, Day, Year)*: APR 0 5 2001
32. Registrar's Signature: [signature] G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Melvin Lee Fenzel

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 10378

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Frank J. Fraer

2. Date of Death: Month MARCH Day 30, Year 2001

3. Time of Death: 9:35 PM

4a. Facility Name (If not institution, give street and number): Stella Maris at Mercy Hospital

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: N/A

Funeral Director

5. Social Security Number: 212-07-1423

6. Sex: 1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday): 84 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): May 3, 1916

9. Birthplace (State or Foreign Country): MD

Usual Residence of Decedent

10a. State: MD

10b. County: N/A

10c. City, Town or Location: Baltimore City

10d. Inside City Limits: ☒ 1 Yes 2 ☐ No

10e. Street and Number: 1438 Reynolds Street

10f. Zip Code: 21230

10g. Citizen of What Country? USA

11. Marital Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? ☒ 1 Yes 2 ☐ No If Yes, Give Year or Dates: Army 41-45

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 10 | College (1-4or 5+): 0

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Alarm Installer

16b. Kind of Business/Industry: Security

17. Father's Name (First, Middle, Last): Frank Fraer

18. Mother's Name (First, Middle, Maiden Surname): Magdalena Seif

19a. Informant's Name/Relationship (Type, Print): Catherine Fraer / Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1438 Reynolds Street, Baltimore MD 21230

20a. Method of Disposition: ☒ 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Holy Cross Cem. April 3, Date: 2001

20c. Location - City or Town, State: Baltimore MD

21. Signature of Funeral Service Licensee: Victor P. Doda, Jr.

22. Name and Address of Facility: Charles L. Stevens Funeral Home, Inc. 1501 East Fort Avenue, Baltimore Maryland 21230

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Respiratory Failure
Due to (or as a consequence of):
b. Demented

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
Colon Cancer
Hypertension

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No

26. Place of Death (Check only one): STELLA MARIS AT MERCY
Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA
Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Hospice

27. Manner of Death: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1 ☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: MD

29c. License number: D40854

29d. Date signed (Month, Day, Year): April 2, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): DAVID RISEBERG 301 St Paul Pl Baltimore MD 21202

State Registrar

31. Date filed (Month, Day, Year): APR 05 2001

32. Registrar's Signature: G Sparks

To be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Amend Item#14 perFHg794 4/5/01 EW

Certificate of Death

Reg. No. 2001 10379

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): TESSIE FREDERICK
2. Date of Death (Month, Day, Year): APRIL 2, 2001
3. Time of Death: 8:30am
4a. Facility Name (If not institution, give street and number): 1815 E. CHASE STREET
4b. City, Town, or Location of Death: BALTIMORE
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 215-30-7000
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 69 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): JAN.8,1932
9. Birthplace (State or Foreign Country): MARYLAND

Usual Residence of Decedent

10a. Stete: MARYLAND
10b. County: N/A
10c. City, Town or Location: BALTIMORE
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 1815 E. CHASE STREET
10f. Zip Code: 21213
10g. Citizen of What Country?: U.S.A.

11. Meritel Stetus: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced
12. Wes Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yeer or Dates:
13. Wes Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - Americen Indian, Black, White, etc. Specify: ~~BLSCK~~ Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): | College (1-4or 5+): 1yr
16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired): SUPERVISOR
16b. Kind of Business/Industry: LINEN SERVICE

17. Father's Name (First, Middle, Last): PHILLIP FREDERICK
18. Mother's Neme (First, Middle, Meiden Surneme): WILLIE MAE FITTS

19a. Informent's Neme/Reletionship (Type, Print): LAWRENCE BOWMAN (SON)
19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code): 1815E. CHASE ST. BALTO. MD. 21213

20a. Method of Disposition: 1☒ Burial 2☐ Cremetion 3☐ Removel from Stete 4☐ Donation 5☐ Other (Specify)
20b. Piece of Disposition (Neme of cemetery, crematory or other piece): MD. NATL. MEM. PK.
Dete: APRIL 6,2001
20c. Location - City or Town, Stete: LAUREL MD.

21. Signeture of Funeral Service Licensee: Bernadine Scruggs
22. Neme and Address of Facility: CALVIN B. SCRUGGS FUNERAL HOME 1412 E. PRESTON STREET BALTO. MD. 21213

Physician /Medical Examiner

23a. Part1. Enter the diseese, or complicetions thet caused the deeth. Do not enter the mode of dying, such es cerdiec or respiretory errest, shock, or heert feilure. List only one cause on eech line. (Approximete Intervel Between Onset and Death)

Immediete Ceuse (Finel diseese or condition resulting in deeth):
a. BREAST CANCER, METASTATIC — SIX MONTHS

Due to (or es e consequence of):
b.

Sequentially list conditions, if any, leeding to immediete cause. Enter Underlying Cause (Diseese or Injury that initieted events resulting in deeth) Last

Due to (or es e consequence of):
c.

Due lo (or es e consequence of):
d.

Pert II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Pert I.: CEREBROVASCULAR ACCIDENT

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Wes an eutopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings aveilable prior to completion of cause of deeth? 1☐ Yes 2☐ No

25. Wes case referred to medicel examiner? 1☐ Yes 2☒ No
26. Place of Deeth (Check only one): Hospitel: 1☐ Inpetient 2☐ ER/Outpetient 3☐ DOA | Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Menner of Death: 1☒ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigetion 6☐ Could not be determined
28a. Dete of Injury (Month, Dey Yeer)
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Piece of Injury - At home, ferm, street, fectory, office building, etc. (Specify)
28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, dete end place, end due to the cause(s) end manner as stated. 2☐ **Medical Examiner:** On the basis of exeminetion and/or investigetion, in my opinion, deeth occurred et the time, date end place, and due to the cause(s) and menner steted.

29b. Signeture and title of certifier: Sydney Byrd PHYSICIAN
29c. License number: D53590
29d. Date signed (Month, Dey, Yeer): APRIL 4, 2001

30. Neme end address of person who completed cause of death (Item 23a) (Type, Print): SYDNEY BY, MD CARNEGIE 291 JOHNS HOPKINS HOSPITAL 600 N. WOLFE ST BALTIMORE MD 21287

State Registrar

31. Dete filed (Month, Dey, Yeer): 05 2001
32. Registrer's Signeture: Geneva G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

01-1799-510
mnmr
Dirk R. Freeman

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

1- For State Registrar AMEND ITEM 23a,27,28a-f per ME G794 041301 SS

Reg. No. 2001 10380

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
DIRK R. FREEMAN	April 02, 2001	1754 pM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
708 North Duncan Street	Baltimore	N/A

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
217-66-6732	1☒M 2☐F	44 Yrs.			11-14-1956	MARYLAND

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD.	N/A	BALTIMORE	1☒Yes 2☐No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
708 N. DUNCAN ST.	21205	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Rece - American Indien, Black, White, etc.
1☐Never Married 2☐Married 3☐Widowed 4☒Divorced	1☐Yes 2☒No If Yes, Give Year or Dates:	1☐Yes 2☒No Specify:	Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
-12-	-4-	STEAM FITTER WELDER	WELDING

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
JERRY R. FREEMAN	MAYOLA MANNING

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
TIVOLA ARTIS(SISTER)	4531 FINNEY AVE. BALTIMORE, MARYLAND 21215

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	WOODLAWN CEMETERY	4-7-2001	BALTIMORE, MARYLAND

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ Jonatha D. Hubner	PHILLIPS FUNERAL HOME, P.A. 1721-27 N. MONROE ST. BALTIMORE, MARYLAND 21217

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. NARCOTIC, COCAINE AND ALCOHOL INTOXICATION	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of):	
	c. Due to (or as a consequence of):	
	d. Due to (or as a consequence of):	

IF FEMALE: 23b. Was decedent pregnent in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month Day Year
1☐Yes 2☐No 9☐Unknown	1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnent at time of death 5☐Other (specify) _____ 9☐Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobecco use contribute to the cause of death?	24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐Yes 2☐No 3☐Probably 4☐Unknown	1☒Yes 2☐No	1☒Yes 2☐No

25. Wes case referred to medical examiner?	26. Place of Death (Check only one)	
1☒Yes 2☐No	Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA	Other: 4☐Nursing Home 5☐Residence 6☒Other (Specify) at scene

Medical Certification; To Be Completed by Physician/Medical Examiner

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☐Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☒Could not be determined	found: 4-2-01	unknown M	1☐Yes 2☒No	unknown

28e. Place of Injury - At home, farm, street, factory, offica building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)
home	708 N. Duncan St., Balto., MD

29a. Certifier (Check only one) 1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) end manner es stated. ☒☒ **Medical Exeminer:** On the basis of examinetion and/or investigation, in my opinion, deeth occurred et the time, date end place, end due to the cause(s) end manner stated.

29b. Signature and title of certifier	29c. Licanse number	29d. Dete signed (Month, Day, Year)
▶ [signature]	O.C.M.E.	April 03, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

J. Allen Locke, MD 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
APR 05 2001	[signature]

DHMH 17 Rev 1/2001

ORIGINAL

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 10381

NAME KNOWN TO PHYSICIAN: LYNWOOD GLASGOW

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 28a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Lynwood Glasgow
2. Date of Death Month Day Year: APRIL 4, 2001
3. Time of Death: 2:25 PM
4a. Facility Name *(If not institution, give street and number)*: VA MARYLAND HEALTH CARE SYSTEM
4b. City, Town, or Location of Death: PERRY POINT
4c. County of Death: CECIL

Funeral Director

5. Social Security Number: 223-36-3597
6. Sex: 1 [X] M 2 [ ] F
7. Age *(In yrs. last birthday)*: 70 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: MAR 30, 1931
9. Birthplace *(State or Foreign Country)*: Virginia

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: Maryland
10b. County: Harford
10c. City, Town or Location: Joppa
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 800 Ferguson Road
10f. Zip Code: 21085
10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: 1953-1955
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 6; College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Ship Painter
16b. Kind of Business/Industry: Shipyard

17. Father's Name *(First, Middle, Last)*: Dan Glasgow
18. Mother's Name *(First, Middle, Maiden Surname)*: Lavinia Hargrove

19a. Informant's Name/Relationship *(Type, Print)*: Yvonne W. Glasgow/Wife
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 800 Ferguson Road Joppa, MD 21085

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Metro Crematory Inc.
Date: 4-5-01
20c. Location - City or Town, State: Baltimore, MD

21. Signature of Funeral Service Licensee: Edward A. Gregorchik
Edward A. Gregorchik
22. Name and Address of Facility: Cremation Society of MD, Inc. 299 Frederick Road Baltimore, MD 21228

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. MYOCARDIAL INFARCTION — 1 DAY
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
RESPIRATORY FAILURE
CARDIOVASCULAR ACCIDENT

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No
26. Place of Death *(Check only one)*: Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other *(Specify)*
27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier *(Check only one)*: 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: S. Sodhi
29c. License number: D42014
29d. Date signed *(Month, Day, Year)*: APRIL 4, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): SURINDERPAL SODHI, M.D., VA MARYLAND HEALTH CARE SYSTEM, PERRY POINT, MD 21902

State Registrar

31. Date filed *(Month, Day, Year)*: APR 05 2001
32. Registrar's Signature: D. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 10382

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): David Greenwood
2. Data of Death: Month April Day 3rd Year 2001
3. Time of Death: 2:00 Pm
4a Facility Name (If not institution, give street and number): Harbor Hospital Center
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 025-32-9599
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 58 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Data of Birth (Month, Day, Year): NOV 24, 1942
9. Birthplace (State or Foreign Country): Massachusetts

Usual Residence of Decedent

10a. State: Maryland
10b. County: N/A
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 3715 Pascal Avenue
10f. Zip Code: 21226
10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Nevar Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever In U.S. Armed Forcas? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexicen, Puerto Rican, atc.) 1 [ ] Yas 2 [X] No Specify:
14. Race - Amaricen Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elemantary/Secondary (0-12): 9 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Carpenter
16b. Kind of Business/Industry: Carpentry

17. Father's Name (First, Middle, Last): UNK.
18. Mother's Nama (First, Middle, Maiden Surneme): Lorraine C. LaCroix

19a. Informant's Name/Ralationship (Type, Print): Elizabeth A. Greenwood/Wife
19b. Malling Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda): 3715 Pascal Avenue Baltimore, MD 21226

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cramation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Nama of cemetery, crematory or other place): Metro Crematory Inc.
Data: 4-5-01
20c. Location - City or Town, Stata: Baltimore, MD

21. Signature of Funeral Service Licensee: Edward A. Gregorchik
Edward A. Gregorchik
22. Name and Address of Facility: Cremation Society of MD, Inc. 299 Frederick Road Baltimore, MD 21228

Physician /Medical Examiner

23a. Part1. Enter tha disease, or complications that caused the death. Do not entar the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line.

Approximata Interval Between Onset and Death

Immediate Cause (Final disaase or condition rasulting in death)
a. Acute Myocardial Infarction — 1 hour

Dua to (or as a consequance of):
b. Coronary Arterial disease — 5 years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseasa or Injury that initiated events resulting in death) Last

Dua to (or as a consequance of):
c.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause givan in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [/] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [/] No
24b. Wara autopay findings available prior to completion of ceuse of death? 1 [ ] Yas 2 [ ] No

25. Wes case referred to medical examiner? 1 [ ] Yes 2 [/] No
26. Placa of Death (Check only ona): Hospital: 1 [/] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [/] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Dey Year)
28b. Time of Injury
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, Stata)

29a. Certifier (Check only one): 1 [/] **Certifying Phyeician**: To tha best of my knowledge, death occurred at tha tima, data and place, and dua to tha cause(s) and manner es stated. 2 [ ] **Medical Examiner**: On the basia of examination and/or investigation, in my opinion, daath occurred at the time, date and place, and due to tha cause(s) and manner stated.

29b. Signature and titla of certifier: MF (M.D)
29c. License number: SEA - AS 2441614 - A37
29d. Date signed (Month, Day, Year): April 3rd 2001

30. Nama and address of person who completed ceuse of death (Item 23a) (Type, Print): MYO HTUT, 3001 South Hanover Street, Baltimore, MD 21225

State Registrar

31. Date filed (Month, Dey, Year): APR 05 2001
32. Registrar's Signature: Paula P. Parks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

CPS
01-1832-005
ELAINE GEISZ

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 10383

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Elaine C. Geisz
2. Date of Death: Month April Day 3, Year 2001
3. Time of Death: 11:48 AM
4a. Facility Name (If not institution, give street and number): GREATER BALTIMORE MEDICAL CENTER
4b. City, Town, or Location of Death: TOWSON
4c. County of Death: BALTIMORE

Funeral Director

5. Social Security Number: 215-46-5586
6. Sex: 1☐M 2☒F
7. Age (In yrs. last birthday): 53 Yrs.
If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): April 16, 1947
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Baltimore
10c. City, Town or Location: Phoenix
10d. Inside City Limits: 1☐Yes 2☒No
10e. Street and Number: 10 Tojan Horse Drive
10f. Zip Code: 21131
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐Never Married 2☐Married 3☐Widowed 4☒Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐Yes 2☒No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12): 12 yrs.
College (1-4or 5+): 8 yrs.
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Administrator
18b. Kind of Business/Industry: Education

17. Father's Name (First, Middle, Last): Joseph Tomko
18. Mother's Name (First, Middle, Maiden Surname): Bernice Meade

19a. Informant's Name/Relationship (Type, Print): Steven F. Geisz, II / Son
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 10 Trojan Horse Drive Phoenix, Maryland 21131

20a. Method of Disposition: 1☐Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☒Other (Specify) Entombment
20b. Place of Disposition (Name of cemetery, crematory or other place): Dulaney Valley Mem. Gds.
Date: 4/7/01
20c. Location - City or Town, State: Timonium, Maryland

21. Signature of Funeral Service Licensee: Earl L. Canapp, CFSP
22. Name and Address of Facility: Ruck Towson Funeral Home, Inc. 1050 York Rd. Towson, Md. 21204

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. Occlusive Pulmonary Thromboemboli
Due to (or as a consequence of):
b. Deep Vein Thrombosis in
Due to (or as a consequence of):
c. Association With Arthroplasty
Due to (or as a consequence of):
d. Of Second Toe For Hammertoe

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Approximate Interval Between Onset and Death

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐Yes 2☐No 9☒Unknown
23c. If yes, outcome of pregnancy: 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown
23d. Date of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☑No 3☐Probably 4☐Unknown

24a. Was an autopsy performed? 1☑Yes 2☐No
24b. Were autopsy findings available prior to completion of cause of death? 1☑Yes 2☐No

25. Was case referred to medical examiner? 1☒Yes 2☐No

28. Place of Death (Check only one)
Hospital: 1☐Inpatient 2☒ER/Outpatient 3☐DOA
Other: 4☐Nursing Home 5☐Residence 8☐Other (Specify)

27. Manner of Death: 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1☐Yes 2☐No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification; To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end manner as steted.
☒ **Medical Examiner:** On the basis of exemination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: J. Pestaner M.D.
29c. License number: OCME
29d. Date signed (Month, Day, Year): April 4, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Joseph Pestaner 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year): APR 05 2001
32. Registrar's Signature: Penina G Sparks

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial transit permit.

Division of Vital Records, P.O. Box 68760,

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 10384

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Janice B. Gulick

2. Date of Death: Month April Day 3 Year 2001

3. Time of Death: 5:45 P M

4a. Facility Name (If not institution, give street and number): Manor Care Towson

4b. City, Town, or Location of Death: Towson

4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 141-50-3796

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 85 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): 10/06/1915

9. Birthplace (State or Foreign Country): New Jersey

Usual Residence of Decedent

10a. State: MD

10b. County: Baltimore

10c. City, Town or Location: Lutherville

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 1420 Front Ave.

10f. Zip Code: 21093

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: white

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 12

College (1-4or 5+): 2

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Home Maker

16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): Victor Brook

18. Mother's Name (First, Middle, Maiden Surname): Madeline Paige

19a. Informant's Name/Relationship (Type, Print): Carol Snyder / daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1411 Putty Hill Ave.; Towson, MD 21286

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Hilltop Service Corp

Date: 4/6/01

20c. Location - City or Town, State: Towson, MD

21. Signature of Funeral Service Licensee: Peter U Adams

22. Name and Address of Facility: Ruck Towson Funeral Home, 1050 York Road, Towson, MD 21204

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If Item 27 is marked other than "natural", or Items 23e or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. stroke — 4 years

Due to (or as a consequence of):

b. atherosclerotic cerebrovascular disease — 25 years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1☐ Yes 2☒ No 9☐ Unknown

23c. If yes, outcome of pregnancy: 1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) 9☐ Unknown

23d. Date of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

dementia

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

28. Place of Death (Check only one)

Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA

Other: 4☒ Nursing Home 5☐ Residence 8☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification; To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

29a. Certifier (Check only one): 1☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: MD

29c. License number: D41104

29d. Date signed (Month, Day, Year): 4.4.01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Ted Hook MD 7825 York Rd Towson MD 21204

State Registrar

31. Date filed (Month, Day, Year): APR 05 2001

32. Registrar's Signature: Geneva G Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 10385

Patient known as Nina Groom

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: NINA GRACE GROOM
2. Date of Death Month Day Year: April 3, 2001
3. Time of Death: 9:15 a.m.
4a. Facility Name *(If not institution, give street and number)*: Sinai Hospital of Baltimore
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 409-14-9312
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 83 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: Sept. 11, 1917
9. Birthplace *(State or Foreign Country)*: TN

Usual Residence of Decedent

10a. State: MD
10b. County: Carroll
10c. City, Town or Location: Hampstead
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 4751 Maple Grove Rd.
10f. Zip Code: 21074
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 | College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Book Department
16b. Kind of Business/Industry: Baltimore County Board of Education

17. Father's Name *(First, Middle, Last)*: William Floyd Fritts
18. Mother's Name *(First, Middle, Maiden Surname)*: Grace Lueile Moore

19a. Informant's Name/Relationship *(Type, Print)*: Mrs. Grace A. Naylor/daughter
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 4751 Maple Grove Rd. Hampstead, MD 21074

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Prospect Hill Cemetery
Date: 4/6/01
20c. Location - City or Town, State: Towson, MD

21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: Ruck Towson Funeral Home, Inc. 1050 York Rd. Towson, MD 21204

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Pneumonia

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Dementia

HTN

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death *(Check only one)*: Hospital: 1☑ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day, Year)*
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.
Baltimore, Maryland 21215-0036
Division of Vital Records, P.O. Box 68760,

29a. Certifier *(Check only one)*: 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature] DO
29c. License number: RES-000
29d. Date signed *(Month, Day, Year)*: April 3, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): MARYAM KASHI, DO SINAI HOSPITAL OF BALTIMORE

State Registrar

31. Date filed *(Month, Day, Year)*: APR 05 2001
32. Registrar's Signature: [signature]

ORIGINAL

DHMH 16 Rev 6/95

RKD

01-1764-027

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

JASMINE GRABOWSKI

1- For State Registrar AMEN ITEM 23a,27,28a-f per ME G795 053001 SS

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 10386

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
Jasmine Raye Grabowski	MARCH 30, 2001	9:25A. M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
HOWARD COUNTY GENERAL	COLUMBIA	HOWARD

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
218-59-3278	1☐M 2☒F	Yrs.	2		Jan. 21, 2001	MD

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD.	Howard	Columbia	1☐Yes 2☒No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
8850 Tamar Drive Apt.101	21045	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☒Never Married 2☐Married 3☐Widowed 4☐Divorced	1☐Yes 2☒No If Yes, Give Year or Dates:	1☐Yes 2☒No Specify:	Specify: white

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
0		n/a	n/a

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Tyson Day	Melanie Grabowski

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Melanie Grabowski-mother	8850 Tamar Drive Apt.101,Columbia,MD 21045

20e. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	Crestlawn Memorial	04-04-2001	Marriottsville, MD

21. Signeture of Funeral Service Licensee	22. Name and Address of Facility
▶	Witzke Funeral Home-columbia 5555 Twin Knolls Rd.,Columbia, MD.

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one ceuse on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Finel diseese or condition resulting in death)	a. SUDDEN UNEXPECTED DEATH IN INFANCY	
Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of): b.	
	Due to (or as a consequence of): c.	
	Due to (or as a consequence of): d.	

IF FEMALE: 23b. Was decedent pregnent in the pest 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month Day Year
1☐Yes 2☒No 9☐Unknown	1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnent at time of death 5☐Other (specify) 9☐Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobecco use contribute to the cause of death?	24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐Yes 2☒No 3☐Probebly 4☐Unknown	1☒Yes 2☐No	1☒Yes 2☐No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☒Yes 2☐No	Hospital: 1☐Inpatient 2☒ER/Outpatient 3☐DOA	Other: 4☐Nursing Home 5☐Residence 8☐Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☐Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☒Could not be determined	found: 3-30-01	found: 8:30 AM	1☐Yes 2☒No	unknown

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)
found at home	8850 Tamar Dr., #101 Columbia, Maryland

29e. Certifier (Check only one)
1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as steted.
2☒ **Madical Examinar:** On the basis of exemination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the ceuse(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ J. M. T.	O.C.M.E.	MARCH 31,2001

30. Neme and address of person who completed cause of death (Item 23a) (Type, Print)
JACK M. TITUS, M.D. 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
APR 05 2001	▶ J. Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No: 2001 10387

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
IDA GENSLER	MARCH 31, 2001	10:15 PM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
FUTURE CARE CANTON HARBOR	BALTIMORE	N/A

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
212-01-2221	1☐ M 2☒ F	79 Yrs.			8/27/21	MD

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	N/A	BALTIMORE	1☒ Yes 2☐ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
816 S. DECKER AVE.	21224	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced	1☐ Yes 2☒ No If Yes, Give Year or Dates:	1☐ Yes 2☒ No Specify:	Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
4	0	HOMEMAKER	HOME

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
JOHN SKWIRUT	JOSEPHINE ROLKA

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
WILLIAM GENSLER SR.	816 S. DECKER AVE. BALTO., MD. 21224

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☐ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☒ Other (Specify) entombment	HOLLY HILL MEM.	4/4/01	MIDDLE RIVER, MD.

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ Eugene J Kaczorowski	KACZOROWSKI FUNERAL HOME P.A. 1201 DUNDALK AVE. BALTO., MD. 21222

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. CORONARY ARTERY DISEASE	2 yr
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of):	
	c. Due to (or as a consequence of):	
	d. Due to (or as a consequence of):	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month Day Year
1☐ Yes 2☐ No 9☐ Unknown	1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) 9☐ Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

DEMENTIA

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐ Yes 2☒ No	1☐ Yes 2☒ No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐ Yes 2☒ No	Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA	Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	26d. Describe how injury occurred
1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined		M	1☐ Yes 2☐ No	
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			26f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification; To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one)
1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ MD	D47945	APR 03 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
HANIS ALEGRE 9101 FRANKLIN SQUARE DRIVE BALTIMORE MD 21237

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
APR 05 2001	▶ Geneva G Sparks

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23e or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 10388

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): THELMA T. GRIFFIN
2. Date of Death: Month APR Day 03 Year 2001
3. Time of Death: 2:40 AM
4e. Facility Name (If not institution, give street and number): ST. AGNES HOSPITAL
4b. City, Town, or Location of Death: BALTIMORE
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 218-07-7588
6. Sex: 1☐ M 2☑ F
7. Age (In yrs. last birthday): 81 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 11-04-1919
9. Birthplace (State or Foreign Country): VA

Usual Residence of Decedent

10a. State: MD
10b. County: N/A
10c. City, Town or Location: BALTIMORE
10d. Inside City Limits: 1☑ Yes 2☐ No
10a. Street and Number: 3029 SEAMON AVENUE
10f. Zip Code: 21225
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☑ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☑ No If Yes, Give Yaar or Datas:
13. Wes Decedent of Hispanic Origin? (Specify Yas or No- If Yas, specify Cuban, Mexican, Puerto Rican, atc.): 1☐ Yes 2☑ No Specify:
14. Race - American Indian, Black, White, atc. Specify: BLACK

15. Decedent's Education (Specify only highest grade completed): Elementery/Secondery (0-12): 12TH GRADE | College (1-4or 5+): N/A
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use ratired): JANITOR
16b. Kind of Business/Industry: BALTO. COUNTY SCHOOLS

17. Father's Name (First, Middle, Last): WILLIAM TURNER
18. Mother's Neme (First, Middle, Maiden Surname): JULIA BRAXTON

19e. Informent's Neme/Reletionship (Type, Print): MARY TURNER | SISTER IN LAW
19b. Meiling Addrass (Straat and Number or Rural Routa Number, City or Town, State, Zip Code): 917 WICKLOW RD., BALTO. MD. 21229

20e. Method of Disposition: 1☑ Burial 2☐ Cremetion 3☐ Removal from Stete 4☐ Donetion 5☐ Othar (Specify)
20b. Placa of Disposition (Name of cemetery, cremetory or othar place): MT. ALBURN CEMETERY
Date: 4-6-01
20c. Location - City or Town, Stete: BALTO. MD

21. Signature of Funerel Service Licensee: ▶ Vaughn C [illegible]
22. Name and Addrass of Facility: VAUGHN C. GREENE FUNERAL SERVICE 5151 BALTO. NATL PIKE, BALTO. MD. 21229

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

23a. Part1. Entar tha disaase, or complications that caused the death. Do not entar tha mode of dying, such es cardiac or respiratory errest, shock, or heart failure. List only one ceuse on each line.

Approximata Interval Between Onset and Deeth

Immediate Ceuse (Finel diseese or condition resulting in deeth):
a. UROSEPSIS — 1 DAY

Dua to (or as a consequanca of):
b. SUPRAVENTRICULAR TACHYCARDIA — 12 HOURS

Sequentially list conditions, if any, leeding to immedieta cause. Entar Underlying Ceuse (Diseese or Injury that Initieted events resulting in deeth) Last

Due to (or as e consequenca of):
c. RENAL FAILURE

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to deeth but not resulting in the underlying cause given in Part I.: DEMENTIA, DIABETES MELLITUS, HTN

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24e. Wes en eutopsy performed? 1☐ Yas 2☒ No

24b. Wara autopsy findings aveilable prior to completion of cause of deeth? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Plece of Death (Check only ona): Hospital: 1☒ Inpatient 2☐ ER/Outpetient 3☐ DOA Other: 4☐ Nursing Homa 5☐ Residenca 6☐ Other (Specify)

27. Mannar of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined

28e. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28a. Placa of Injury - At homa, farm, streat, factory, office building, etc. (Specify)
28f. Location (Streat end Number or Rurel Route Number, City or Town, Stata)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, deeth occurred at the time, dete end pleca, end due to the causa(s) and menner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, daath occurred at tha tima, date and place, and dua to tha cause(s) and menner steted.

29b. Signetura and title of certifier: ▶ Anna Korzan, MD
29c. Licensa number: P-12704
29d. Date signed (Month, Day, Year): APR 03 2001

30. Name end address of person who complated cause of deeth (Item 23a) (Type, Print): ANNA KORZAN 900 CATON AVE BALTIMORE, MD 21229

State Registrar

31. Date filed (Month, Dey, Year): APR 05 2001
32. Registrer's Signatura: ▶ Penny G Sparks

NAME GRIFFIN, THELMA

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 10389

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Bonny M. Hilditch
2. Date of Death: Month April Day 4 Year 2001
3. Time of Death: 11:30A^M
4a. Facility Name (If not institution, give street and number): 2223 East Baltimore Street
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 151-38-3052
6. Sex: 1☐M 2☒F
7. Age (In yrs. last birthday): 53 Yrs.
If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): MAY 19, 1947
9. Birthplace (State or Foreign Country): New Jersey

Usual Residence of Decedent

10a. State: Maryland
10b. County: N/A
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1☒Yes 2☐No
10e. Street and Number: 2223 East Baltimore Street
10f. Zip Code: 21231
10g. Citizen of What Country? USA

11. Marital Status: 1☐Never Married 2☐Married 3☐Widowed 4☒Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐Yes 2☒No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No Specify:
14. Race - American Indian, Black, White, etc. Specify: Asian

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12); College (1-4or 5+): 5 +
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Librarian
18b. Kind of Business/Industry: John Hopkins University

17. Father's Name (First, Middle, Last): UNK.
18. Mother's Name (First, Middle, Maiden Surname): UNK.

19a. Informant's Name/Relationship (Type, Print): Jeffery F. Hilditch/Son
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): H.C. 77 Box 352 Hinton, WV 25951

20a. Method of Disposition: 1☐Burial 2☒Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Metro Crematory Inc.
Date: 4-5-01
20c. Location - City or Town, State: Baltimore, MD

21. Signature of Funeral Service Licensee: Dawn F. McDonald
22. Name and Address of Facility: Cremation Society of MD, Inc. 299 Frederick Road Baltimore, MD 21228

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death): a. Congestive heart failure
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d.

Approximate Interval Between Onset and Death: 5 years

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐Yes 2☐No 9☐Unknown
23c. If yes, outcome of pregnancy: 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown
23d. Date of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☐Unknown

24a. Was an autopsy performed? 1☐Yes 2☒No
24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☐No

25. Was case referred to medical examiner? 1☒Yes 2☐No

28. Place of Death (Check only one): Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA; Other: 4☐Nursing Home 5☒Residence 8☐Other (Specify)

27. Manner of Death: 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1☐Yes 2☐No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: John M. Hare
29c. License number: D0048124
29d. Date signed (Month, Day, Year): April 5, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): John M. Hare, M.D. 600 N. Wolfe Street Baltimore, MD 21287

State Registrar

31. Date filed (Month, Day, Year): APR 09 2001
32. Registrar's Signature:

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23e or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification; To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 10390

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
Robert Arlet Henry	April 2, 2001	6:55pm M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
VAMHCS Fort Howard Division	Fort Howard	Baltimore

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
162206473	1☒ M 2☐ F	75 Yrs.			DEC 20, 1925	Pennsylvania

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Harford	Joppa	1☐ Yes 2☒ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
324 Foster Knoll Drive	21085	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced	1☒ Yes 2☐ No If Yes, Give Year or Dates: 1941-1973	1☐ Yes 2☒ No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
	4	Navy	US Government

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Archibald Henry	Leah Osterhaut

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Charles Henry/Son	324 Foster Knoll Drive Joppa, MD 21085

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)	Metro Crematory Inc.	4-3-01	Baltimore, MD

21. Signature of Funeral Service Licensee: ▶ Thomas Gregor — Thomas Gregor

22. Name and Address of Facility: Cremation Society of MD, Inc. 299 Frederick Road Baltimore, MD 21228

Physician /Medical Examiner

Medical Certification; To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Non-Small Cell Carcinoma, Lung	3years
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of): b. Bone Metastases	1year
	Due to (or as a consequence of): c.	
	Due to (or as a consequence of): d.	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month Day Year
1☐ Yes 2☐ No 9☐ Unknown	1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) 9☐ Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

28. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? 1☐ Yes 2☐ No	28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ John S. Lah MD	34359 (OHIO)	4 2 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

John Lah MD 9600 North Point Rd, Fort Howard, MD 21052

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
APR 05 2001	▶ Rebecca B. Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Name: Robert A Henry
Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print In Black Indellble Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No: 2001 10391

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): RANDOLPH – Hughes
2. Date of Death: Month April Day 02 Year 2001
3. Time of Death: 5:15 PM
4a. Facility Name (If not institution, give street and number): Chemywood Nursing Home
4b. City, Town, or Location of Death: Reisterstown, MD
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 217-03-8355
6. Sex: 1 ☒ M 2 ☐ F
7. Age (In yrs. last birthday): 92 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): NOVEMBER 17, 1908
9. Birthplace (State or Foreign Country): NORTH CAROLINA

Usual Residence of Decedent

10a. State: MARYLAND
10b. County: BALTIMORE
10c. City, Town or Location: REISTERSTOWN
10d. Inside City Limits: 1 ☒ Yes 2 ☐ No
10e. Street and Number: 12020 REISTERSTOWN ROAD
10f. Zip Code: 21136
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☒ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: BLACK

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12TH GRADE; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): NURSING ASSISTANT
16b. Kind of Business/Industry: HOSPITAL

17. Father's Name (First, Middle, Last): JOHN HUGHES
18. Mother's Name (First, Middle, Maiden Surname): JUDY BARNARD

19a. Informant's Name/Relationship (Type, Print): HOWARD HUGHES (NEPHEW)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4016 FORDS LANE, APT. D, BALTIMORE, MD 21215

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): HUGHES CEMETERY
Date: 04-07-2001
20c. Location - City or Town, State: CAMDEN, NORTH CAROLINA

21. Signature of Funeral Service Licensee: ▶ [signature]
22. Name and Address of Facility: JOSEPH H. BROWN JR. FUNERAL HOME 2140 N. FULTON AVE., BALTIMORE, MARYLAND 21217

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Sepsis
Due to (or as a consequence of):
b. Multi-infarct Dementia
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c. Atherosclerotic Heart Disease
Due to (or as a consequence of):
d. Insulin Dependent Diabetes Mellitus

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
Hypertension

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No
26. Place of Death (Check only one): Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
28a. Date of Injury (Month, Day Year): NA
28b. Time of Injury: M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: ▶ [signature] MD
29c. License number: D37035
29d. Date signed (Month, Day, Year): April 03, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): 5400 OLD COURT RD Suite 205 Randallstown, Md. 21133

State Registrar

31. Date filed (Month, Day, Year): APR 05 2001
32. Registrar's Signature: ▶ [signature]

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 28a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 10392

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Minnie A. Helminiak
2. Date of Death (Month, Day, Year): April 4, 2001
3. Time of Death: 11:40 AM
4a. Facility Name (If not institution, give street and number): Ivy Hall Geriatric and Rehabilitation Center
4b. City, Town, or Location of Death: Middle River
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 218-03-7631
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 95 Yrs. — If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Oct. 18, 1905
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Baltimore
10c. City, Town or Location: Middle River
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 13219 Eastern Avenue
10f. Zip Code: 21220
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 7; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Seamstress
16b. Kind of Business/Industry: Clothing

17. Father's Name (First, Middle, Last): Joseph Kahler
18. Mother's Name (First, Middle, Maiden Surname): Elizabeth Martin

19a. Informant's Name/Relationship (Type, Print): Arthur Chester (son)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3501 Longanview Drive, Baltimore, Maryland 21222

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetary, crematory or other place): Green Mount Crematory
Date: April 5, 2001
20c. Location - City or Town, State: Baltimore, Maryland

21. Signature of Funeral Service Licensee: Brian W. Burke M01267
22. Name and Address of Facility: Bruzdzinski Funeral Home P.A. 1407 Old Eastern Avenue, Essex, Maryland 21221

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Cardiac Arrhythmias — 4-5 hrs

Due to (or as a consequence of):
b. Atherosclerotic Cardiovascular disease un-known

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
Malnutrition, COPD, HTN. Advanced Dementia

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day, Year)
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [illegible] MD.
29c. License number: D-38754
29d. Date signed (Month, Day, Year): 04-04-2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): MALIKA WASSEM. 709. EASTERN BLVD, MD - 21221

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Division of Vital Records, P.O. Box 68760,

State Registrar

31. Date filed (Month, Day, Year): APR 05 2001
32. Registrar's Signature: D. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Amend Item#5 perFHg794 /426/01 EW

Certificate of Death

Reg. No. 2001 10393

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Laurie Anne Jackson

2. Date of Death Month Day Year: April 2, 2001

3. Time of Death: 2:17 PM

4a. Facility Name (If not institution, give street and number): Holy Cross Hospital

4b. City, Town, or Location of Death: Silver Spring

4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 215-52-~~6206~~ 6202

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 45 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): June 9, 1955

9. Birthplace (State or Foreign Country): Washington D.C.

Usual Residence of Decedent

10a. State: Maryland

10b. County: Montgomery

10c. City, Town or Location: Wheaton

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 2906 Collins Avenue

10f. Zip Code: 20902

10g. Citizen of What Country: USA

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): ; College (1-4or 5+): 5+

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use ratired): Insurance Executive

16b. Kind of Business/Industry: Insurance Company

17. Father's Name (First, Middle, Last): Dale Jackson

18. Mother's Name (First, Middle, Maiden Surname): Maysel Moore

19a. Informant's Name/Reletionship (Type, Print): Dale Jackson/Father

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 5810 Highway A1A, Apt. 2-B, Vero Beach, FL 32963

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetary, crematory or other place): Metro Crematory, Inc.

Date: 4/6/01

20c. Location - City or Town, State: Baltimore, MD

21. Signature of Funeral Service Licensee: Edward A. Gregorchik

Edward A. Gregorchik

22. Name and Address of Facility: Cremation Society of MD, Inc. 299 Frederick Road Baltimore, MD 21228

Physician /Medical Examiner

23a. Part1. Enter the diseese, or complicetions thet ceused the deeth. Do not enter the mode of dying, such es cerdiac or respiretory errest, shock, or heert feilure. List only one ceuse on eech line.

		Approximete Interval Between Onset end Deeth
Immediate Ceuse (Finel diseasa or condition resulting in deeth) a.	Diffuse Peritonitis	3 days
Due to (or as a consequance of):		
Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceusa (Diseese or injury that initiated avents resulting in daeth) Last b.	Leak of Viscus-possible Duodenal Stump	3 days
Due to (or es e consequance of):		
c.	Subtotal Gastrectomy with Bypass	7 days
Due to (or es a consequence of):		
d.	Morbid Obesity	Long-term

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Was en autopsy performed? 1☑ Yes 2☐ No

24b. Were autopsy findings aveileble prior to completion of cause of death? 1☑ Yes 2☐ No

25. Wes case referred to medical exeminer? 1☐ Yes 2☑ No

26. Plece of Death (Check only one): Hospital: 1☑ Inpatient 2☐ ER/Outpetient 3☐ DOA Other: 4☐ Nursing Home 5☐ Rasidence 6☐ Other (Specify)

27. Manner of Death: 1☑ Naturel 2☐ Accident 3☐ Sulcide 4☐ Homicida 5☐ Pending Investigation 6☐ Could not be determined

28a. Data of Injury (Month, Dey Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify)

28f. Location (Streat end Number or Rurel Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledga, death occurred et the time, date end plece, end due to the ceuse(s) end menner es steted. 2☐ **Medical Examiner:** On tha basis of examinetion end/or investigetion, in my opinion, deeth occurred et the time, date end placa, and dua to the cause(s) end menner stated.

29b. Signeture end title of certifier: William J. Marcus MD

29c. License number: D07040

29d. Dete signed (Month, Day, Year): April 4, 2001

30. Neme end eddress of person who completed cause of deeth (Item 23e) (Type, Print): William Marcus, M.D. 10801 Lockwood Drive, Silver Spring, MD 20901

State Registrar

31. Dete filed (Month, Day, Year): APR 05 2001

32. Registrar's Signature: B. Sparks

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 10394

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): NANCY LEE JONES
2. Date of Death (Month, Day, Year): APRIL 02 2001
3. Time of Death: 0600 AM
4a. Facility Name (If not institution, give street and number): GOOD SAMARITAN HOSPITAL
4b. City, Town, or Location of Death: BALTIMORE
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 219-26-6434
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 63 Yrs.
If Under 1 Yaar: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Data of Birth (Month, Day, Yaar): FEB. 3, 1938
9. Birthplaca (State or Foreign Country): MARYLAND

Usual Residence of Decedent

10a. State: Md.
10b. County: N/A
10c. City, Town or Location: BALTIMORE
10d. Insida City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 1626 HEATHFIELD RD.
10f. Zip Coda: 21239
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Nevar Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Dacedant Evar in U,S. Armed Forcas? 1☐ Yas 2☒ No If Yas, Giva Yaar or Datas:
13. Was Decedent of Hispanic Origin? (Specify Yas or No- If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 1☐ Yas 2☒ No Specify:
14. Raca - American Indian, Black, Whita, atc. Specify: AFRO-AMERICAN

15. Decedent's Education (Specify only highast grada compiated): Elementary/Secondary (0-12): 12TH; College (1-4or 5+):
16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired): ASST. MANAGER
16b. Kind of Business/Industry: CLOTHING STORES

17. Fathar's Nama (First, Middla, Last): JOSEPH E. BUCKSON
18. Mothar's Nama (First, Middle, Maidan Sumama): ANNIE JONES

19a. Informant's Name/Ralationship (Type, Print): ARTHUR R.JONES (HUSBAND)
19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, State, Zip Coda): 1626 HEATHFIELD RD. BALTO,MD. 21239

20a. Mathod of Disposition: 1☒ Burial 2☐ Cramation 3☐ Removal from Stata 4☐ Donation 5☐ Othar (Specify)
20b. Placa of Disposition (Nama of cematery, crematory or othar placa): ARBUTUS MEM. PARK
Data: APR.9,2001
20c. Location - City or Town, Stata: BALTO,MD.

21. Signatura of Funaral Sarvica Licensee: Bernadine T. Scruggs
22. Nama and Addrass of Facility: CALVIN B. SCRUGGS FUNERAL HOME 1412 E. PRESTON ST. BALTO, MD. 21213

Physician /Medical Examiner

23a. Part1. Entar tha disaasa, or complications that caused the death. Do not antar tha moda of dying, such as cardiac or respiratory arrast, shock, or haart failura. List only ona causa on aach lina.

Approximate Intarval Between Onsat and Daath

Immediata Causa (Final diseasa or condition resulting in death)
a. SEPSIS — 4 HOURS

Dua to (or as a consequanca of):
b. ADENOCARCINOMA OF THE OVARIES

Sequentially list conditions, if any, leading to immediate causa. Entar Undarlying Cause (Diseasa or Injury that initiated events resulting in death) Last
Dua to (or as a consequanca of):
c.

Dua to (or as a consequanca of):
d.

Part II. **Other significant conditions** contributing to daath but not rasulting in tha undarlying causa givan in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yas 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yas 2☒ No

24b. Were autopsy findings available prior to completion of causa of death? 1☐ Yas 2☒ No

25. Was casa rafarrad to medical examinar? 1☐ Yes 2☒ No

26. Placa of Death (Check only ona): Hospital: 1☒ Inpatiant 2☐ ER/Outpatient 3☐ DOA; Othar: 4☐ Nursing Homa 5☐ Rasidanca 6☐ Othar (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accidant 3☐ Suicida 4☐ Homicida 5☐ Pending invastigation 6☐ Could not be determinad

28a. Data of Injury (Month, Day Yaar)
28b. Tima of Injury M
28c. Injury at Work? 1☐ Yas 2☐ No
28d. Dascribe how injury occurrad

28a. Placa of Injury - At homa, farm, street, factory, office building, atc. (Specify)
28f. Location (Street and Number or Rural Routa Number, City or Town, State)

29a. Certifiar (Check only ona): 1☒ **Certifying Physician:** To tha best of my knowledga, daath occurrad at tha tima, data and placa, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On tha basis of axamination and/or invastigation, in my opinion, daath occurrad at tha tima, data and placa, and due to tha cause(s) and mannar stated.

29b. Signatura and titla of cartifiar: R. Osih MD
29c. Licansa number: P14420
29d. Data signed (Month, Day, Yaar): APRIL 02 2001

30. Name and address of person who completed causa of death (Itam 23a) (Type, Print): REGINA B. OSIH, GOOD SAMARITAN HOSPITAL, BALTIMORE MD

State Registrar

31. Data filed (Month, Day, Yaar): APR 05 2001
32. Registrar's Signatura: Geneva G Sparks

DHMH 16 Rav 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 10395

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Deta of Death Month Day Yaar	3. Tima of Deeth
James Nowell Jersild	April 4, 2001	9:20 AM M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Locafion of Death	4c. County of Deafh
4106 Duane Avenue Apt. 1	Baltimore	N/A

Funeral Director

5. Social Security Number	6. Sex	7. Aga (In yrs. last birthday)	If Under 1 Year Months	Days	If Under 24 Hrs. Hours	Min.	8. Dala of Birth (Month, Day, Yaar)	9. Birthplace (State or Foreign Country)
478-44-5823	X 1 M 2 F	61 Yrs.					JULY 8, 1939	Iowa

Usual Residence of Decedent

10a. Stata	10b. County	10c. City, Town or Locafion	10d. Insida City Limits
Maryland	N/A	Baltimore	1 X Yes 2 No

10e. Street and Number	10f. Zip Coda	10g. Cilizan of Whal Country?
4106 Duane Avenue Apt. 1	21225	USA

11. Marital Status	12. Was Decedent Evar in U.S. Armed Forcas? If Yas, Give Yaar or Dates:	13. Was Decedent of Hispanic Origin? (Specify Yas or No- If Yes, specify Cuban, Mexican, Puarto Rican, atc.)	14. Race - Amarican Indian, Black, Whita, etc.
1 Never Married 2 X Married 3 Widowed 4 Divorced	1 X Yas 2 No 1957-1963	1 Yas X 2 No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Businass/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12		Truck Driver	Anne Arundel County Department of Public Works

17. Father's Name (First, Middle, Last)	18. Mother's Nema (First, Middle, Maiden Sumame)
Arthur A. Jersild	Meta Mezinger

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Karin B. Jersild/wife	4106 Duane Avenue Apt #1 Baltimore, MD 21225

20a. Method of Disposition	20b. Placa of Disposition (Name of cemetery, cremetory or other place)	Dala	20c. Location - City or Town, Stala
1 Burial 2 X Cremation 3 Removal from Stala 4 Donation 5 Other (Specify)	Metro Crematory Inc.	4-4-01	Baltimore, MD

21. Signature of Funeral Service Licensee
▶ Edward A. Gregorchik

22. Nama and Addrass of Facility
Cremation Society of MD, Inc.
299 Frederick Road Baltimore, MD 21228

Physician /Medical Examiner

23a. Part1. Enter tha diseasa, or complications that caused tha daath. Do not antar the mode of dying, such es cardiac or respiratory arrest, shock, or heart failura. List only ona causa on aach lina.

Approximate Intarval Batween Onsel and Daath

Immediate Cause (Final disease or condition resulting in death) a.	Adenocarcinoma of Pancreas	2 months
Dua to (or as a consequence of): b.	Liver metastasis	2 months
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last — Dua to (or as a consequence of): c.		
Dua to (or as a consequance of): d.		

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yas, outcoma of pregnancy	23d. Dala of dalivary Month Day Year
1 Yes 2 No 9 Unknown	1 Liva birth 2 Fatal daath 3 Ectopic pregnancy 4 Pregnant at tima of deelh 5 Othar (specify) 9 Unknown	

Part II. **Other significant conditions** contributing to death but not rasulting in tha undarlying causa givan in Part I.

23e. Did tobacco usa contributa to tha causa of death?	24a. Was an autopsy performed?	24b. Wara autopsy findings availabla prior to completion of causa of daath?
1 Yas 2 No 3 Probably 4 Unknown	1 Yas 2 X No	1 Yas 2 No

25. Was case rafarrad to medical examiner?	26. Placa of Daath (Check only one)	
1 Yes 2 X No	Hospital: 1 Inpatiant 2 ER/Outpatiant 3 DOA	Othar: 4 Nursing Homa 5 X Residence 8 Othar (Specify)

27. Manner of Death	28a. Data of Injury (Month, Day Year)	28b. Tima of Injury	28c. Injury at Work?	28d. Describa how injury occurred
1 X Natural 2 Accident 3 Suicida 4 Homicida 5 Pending investigation 6 Could not be datarmined		M	1 Yes 2 No	
	28a. Placa of Injury - At homa, farm, straat, factory, office building, atc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1 X **Certifying Physician:** To tha best of my knowledga, death occurrad at tha tima, date and placa, and dua to tha causa(s) and manner as stated.
2 **Medical Examiner:** On tha basis of examination and/or investigation, in my opinion, daath occurrad at tha time, date and placa, and dua to tha causa(s) and manner stated.

29b. Signature and title of certifier	29c. Licensa number	29d. Data signad (Month, Day, Yaar)
▶ G. Nimmagadda	D 39041	April 4th 2001

30. Name and address of person who completed cause of daath (Item 23a) (Type, Print)
G. NIMMAGADDA 1600 S. Crain Highway Glen Burnie MD 21061

State Registrar

31. Data filed (Month, Day, Yaar)	32. Registrar's Signature
APR 05 2001	▶ Geneva G. Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23e or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

For the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification; To Be Completed by Physician/Medical Examiner

01-1727-510
mnmr
Kimberly Kimble

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 10396

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
Kimberly Kimble	March 28, 2001	1521 p M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
891 West Lombard Street	Baltimore	N/A

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
214-86-7381	1☐M 2☒F XX	37 Yrs.			Feb. 2, 1964	Maryland

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	N/A	Baltimore	1☒Yes 2☐No

10e. Street and Number	10f. Zip Code	10g. Citizen of Whet Country?
891 W. Lombard Street	21213	United States

11. Merital Status	12. Wes Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Rece - American Indien, Black, White, etc.
1☒Never Married 2☐Married 3☐Widowed 4☐Divorced	1☐Yes 2☒No If Yes, Give Year or Detes:	1☐Yes 2☒No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12 years		Disabled	N/A

17. Fether's Name (First, Middle, Last)	18. Mother's Neme (First, Middle, Meiden Surneme)
Medford Kimble	Betty Breeding

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code)
Betty Horney (Mother)	6421 Eva Street Milton, Florida 32570

20a. Method of Disposition	20b. Place of Disposition (Neme of cemetery, crematory or other piece)	Dete	20c. Location - City or Tewn, Stete
1☐Burial 2☒Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	Hilltop Service Corp.	4/4/2001	Towson, Maryland

21. Signature of Funeral Service Licensee ▶ [signature]

22. Name and Address of Facility
Duda-Ruck Funeral Home of Dundalk, Inc.
7922 Dundalk Avenue Dundalk, Maryland 21222

Physician /Medical Examiner

Medical Certification; To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the diseese, or complicetions that caused the death. Do not enter the mode of dying, such as cerdiec or respiretory errest, shock, or heart feilure. List only one cause on each line.

		Approximate Interval Between Onset and Deeth
Immediate Cause (Final disease or condition resulting in death)	a. Diabetic ketoacidosis	
Sequentially list conditions, if any, leading to immediete cause. Enter Underlying Cause (Diseese or injury thet initiated events resulting in death) Last	b. Due to (or as e consequence of):	
	c. Due to (or es a consequence of):	
	d. Due to (or as e consequence of):	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Dete of delivery Month Day Year
1☐Yes 2☐No 9☐Unknown	1☐Live birth 2☐Fetel deeth 3☐Ectopic pregnancy 4☐Pregnent et time of deeth 5☐Other (specify) 9☐Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probebly 4☐Unknown

24e. Was en eutopsy performed?	24b. Were eutopsy findings available prior to completion of cause of death?
1☒Yes 2☐No	1☒Yes 2☐No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)
XX☒Yes 2☐No	Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☐Residence 8☒Other (Specify) at scene

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury et Work?	28d. Describe how injury occurred
1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined			1☐Yes 2☐No	

28e. Place of Injury - At home, tarm, street, factory, office building, etc. (Specify)

28f. Location (Street end Number or Rurel Route Number, City or Town, State)

29a. Certifier (Check only one)
1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, dete and place, and due to the cause(s) end menner as stated.
2☒ **Medical Examiner:** On the basis of examinetion and/or investigetion, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Yeer)
▶ [signature]	O.C.M.E.	March 29, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
J. Allan Locke, MD 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Dete filed (Month, Day, Year)	32. Registrar's Signature
APR 05 2001	▶ [signature]

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 10397

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Walter Kwarta

2. Date of Death: Month: April Day: 3 Year: 2001

3. Time of Death: 6:33 PM

4a. Facility Name (If not institution, give street and number): Franklin Square Hospital Center

4b. City, Town, or Location of Death: Rosedale

4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 219-32-7993

6. Sex: 1 X M 2 ☐ F

7. Age (In yrs. last birthday): 62 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): April 15, 38

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Baltimore

10c. City, Town or Location: Essex

10d. Inside City Limits: 1 ☐ Yes 2 X No

10e. Street and Number: 213 Nanticoke Road

10f. Zip Code: 21221

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 ☐ Never Married 2 X Married 3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? X Yes 2 ☐ No If Yes, Give Year or Dates: 1954

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 ☐ Yes 2 X No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Restaurateur

16b. Kind of Business/Industry: Restaurant Owner

17. Father's Name (First, Middle, Last): Andrew Kwarta

18. Mother's Name (First, Middle, Maiden Surname): Mary Stachlinski

19a. Informant's Name/Relationship (Type, Print): Margaret Kwarta (wife)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 213 Nanticoke Road, Essex, Maryland 21221

20a. Method of Disposition: 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, cremetory or other place): St. Stanislaus Cemetery

Date: April 7, 2001

20c. Location - City or Town, State: Baltimore, Maryland

21. Signature of Funeral Service Licensee: Leland Bruzdzinski

22. Name and Address of Facility: Bruzdzinski Funeral Home P.A. 1407 Old Eastern Avenue, Essex, Maryland 21221

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Systematic Inflammatory Response Syndrome — 15 DAYS

Due to (or as a consequence of):

b. Pancreatitis — 15 DAYS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 X No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 X No

26. Place of Death (Check only one): Hospital: 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 X Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): X 1 **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated. ☐ 2 **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Lawanda Summers MD

29c. License number: RD196683

29d. Date signed (Month, Day, Year): April 3rd, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Dr. Lawanda Summers 9000 Franklin Square Dr. Baltimore, Maryland 21237

State Registrar

31. Date filed (Month, Day, Year): APR 05 2001

32. Registrar's Signature: G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

WALTER KWARTA

204

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 10399

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)			2. Data of Death Month Day Year	3. Time of Death
SIBYL	GERALDINE	LANCASTER	APRIL 2, 2001	4:30PM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Daath	4c. County of Death
ANNE ARUNDEL MEDICAL CENTER	ANNAPOLIS	ANNE ARUNDEL

Funeral Director

5. Social Security Numbar	6. Sex	7. Aga (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Data of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
213-34-3583	1☐M 2☒F	83 Yrs.			MARCH 1,1918	WV

Usual Rasidance of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MARYLAND	ANNE ARUNDEL	GLEN BURNIE	1☐Yas 2☒No

10e. Street and Number	10f. Zip Coda	10g. Citizan of What Country?
419 B & A BOULEVARD, N.E.	21061	U.S.A.

11. Marital Status	12. Was Decedant Evar in U.S. Armed Forcas?	13. Was Decedant of Hispanic Origin? (Specify Yas or No- If Yes, specify Cuban, Maxican, Puarto Rican, atc.)	14. Race - American Indian, Black, Whita, atc.
1☐Nevar Married 2☐Married 3☒Widowed 4☐Divorced	1☐Yes 2☒No If Yes, Give Yaar or Dates:	1☐Yas 2☒No Specify:	Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	18b. Kind of Businass/Industry
Elementary/Secondary (0-12)	Collega (1-4or 5+)		
12		HOMEMAKER	OWN HOME

17. Father's Name (First, Middle, Last)			18. Mother's Name (First, Middle, Maiden Surname)		
MERIDETH	LEE	BAILEY	ALMA	GRACE	WHITE

19a. Informant's Name/Ralationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
MR. LARRY LANCASTER (SON)	1726 SWINBURNE AVENUE, CROFTON, MARYLAND 21114

20a. Method of Disposition	20b. Placa of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, Stata
1☒Burial 2☐Cremation 3☐Ramoval from Stata 4☐Donatica 5☐Other (Specify)	GLEN HAVEN MEMORIAL PARK	4/5/2001	GLEN BURNIE, MD.

21. Signature of Funaral Service Licansee	22. Nama and Addrass of Facility
▶ [signature] Mo1795	SINGLETON FUNERAL HOME, P.A., 1 SECOND AVENUE, S.W., GLEN BURNIE, MD. 21061

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused tha daath. Do not entar tha moda of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only ona causa on aach lina.

		Approximate Interval Betwaen Onsat and Daath
Immediate Cause (Finat disaase or condition rasulting in death)	a. Brainstem CVA	3 wks
Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or injury that initiated events rasulting in death) Last	Dua to (or as a consaquance of): b. HTN	
	Dua to (or as a consaquance of): c.	
	Dua to (or as a consaquance of): d.	

IF FEMALE: 23b. Was decedent pregnant in tha past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of dalivary Month Day Year
1☐Yes 2☐No 9☐Unknown	1☐Liva birth 2☐Fatal daath 3☐Ectopic pregnancy 4☐Pragnant at time of death 5☐Othar (specify) 9☐Unknown	

Part II. **Other significant conditions** contributing to daath but not resulting in tha underlying causa givan in Part I.

Congestive heart failure, dementia

23e. Did tobacco use contributa to tha cause of death?	24a. Was an autopsy performed?	24b. Wara autopsy findings available prior to compiation of cause of death?
1☐Yas 2☐No 3☐Probably 4☒Unknown	1☐Yas 2☒No	1☐Yas 2☐No

25. Was casa rafarrad to madical axaminer?	28. Place of Death (Check only one)	
1☐Yas 2☒No	Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA	Other: 4☐Nursing Home 5☐Residence 8☐Other (Specify)

27. Mannar of Daath	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Dascribe how injury occurred
1☒Natural 2☐Accidant 3☐Suicida 4☐Homicida 5☐Panding investigation 6☐Could not ba datarmined		M	1☐Yas 2☐No	
	28a. Place of Injury - At home, larm, street, factory, office building, atc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Cartifiar (Check only one) 1☒**Certifying Physician:** To tha bast of my knowledga, daath occurrad at tha tima, data and placa, and due to the causa(s) and manner as stated. 2☐**Medical Examiner:** On tha basis of axamination and/or invastigation, in my opinion, daath occurrad at the tima, data and placa, and dua to tha cause(s) and manner statad.

29b. Signatura and title of cartifiar	29c. License number	29d. Data signed (Month, Day, Year)
▶ [signature] MD	D41816	4/4/2001

30. Nama and address of person who completed cause of death (Item 23a) (Typa, Print)

Charles W. Phelps MD Anne Arundel Medical Center 64 Franklin St. Annapolis, MD 21401

State Registrar

31. Data filad (Month, Day, Year)	32. Registrar's Signatura
APR 05 2001	[signature] G Sparks

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 17 Rav 1/2001

ORIGINAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 10400

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: George Donald Meixel, Sr.
2. Date of Death (Month, Day, Year): April 03, 2001
3. Time of Death: 4:25 P.M.
4a. Facility Name *(If not institution, give street and number)*: 11630 Glen Arm Road Unit L65
4b. City, Town, or Location of Death: Glen Arm
4c. County of Death: Baltimore Co.

Funeral Director

5. Social Security Number: 329-16-1801
6. Sex: 1 [X] M 2 [ ] F
7. Age *(In yrs. last birthday)*: 82 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: October 30, 1918
9. Birthplace *(State or Foreign Country)*: Bayard, Nebraska

Usual Residence of Decedent

10a. State: Maryland
10b. County: Baltimore Co.
10c. City, Town or Location: Glen Arm
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 11630 Glen Arm Road Unit L65
10f. Zip Code: 21057
10g. Citizen of What Country?: United States of America

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No — If Yes, Give Year or Dates: W.W.II
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 [ ] Yes 2 [X] No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 — College (1-4 or 5+): 4
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Executive Manager
16b. Kind of Business/Industry: Heavy Machinery

17. Father's Name *(First, Middle, Last)*: Jesse Laverne Meixel
18. Mother's Name *(First, Middle, Maiden Surname)*: Martha Reetz

19a. Informant's Name/Relationship *(Type, Print)*: (Wife) Mrs. Wanda Mathilde(nee Rosenstock)Meixel
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 11630 Glen Arm Road Unit L65 Glen Arm, Maryland 21057

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*
20b. Place of Disposition *(Name of cemetary, crematory or other place)*: Hilltop Service Corporation
Date: 4/05/2001
20c. Location - City or Town, State: Towson, Maryland

21. Signature of Funeral Service Licensee: Jeffrey L. Gair, Sr.
22. Name and Address of Facility: Ruck Towson Funeral Home, Inc. 1050 York Rd. Towson, Md. 21204

Physician /Medical Examiner

23a. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. PARKINSONS DISEASE — 3 YEARS

Due to (or as a consequence of):
b.

Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
HYPERTENSION, DEMENTIA, BENIGN PROSTATIC HYPERTROPHY, CORONARY ARTERY DISEASE

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No
26. Place of Death *(Check only one)*: Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — Other: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other *(Specify)*

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury *(Month, Day, Year)*
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier *(Check only one)*: 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: R. GOPALAN MD
29c. License number: D57228
29d. Data signed *(Month, Day, Year)*: 4/4/2001
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): RAMANA GOPALAN MD 2 EAST ROLLING CROSS ROADS SUITE 159 BALTIMORE MD 21228

State Registrar

31. Data filed *(Month, Day, Year)*: APR 05 2001
32. Registrar's Signature: Geneva G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 10401

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Hugh S. Melzer
2. Data of Death — Month: April; Day: 3; Year: 2001
3. Time of Death: 4:00 Am
4a. Facility Name *(If not institution, give street and number)*: Good Samaritan Hospital
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: n/a

Funeral Director

5. Social Security Number: 214-14-0309
6. Sex: 1 [X] M 2 [ ] F
7. Age *(In yrs. last birthday)*: 90 Yrs. — If Under 1 Yaar: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Data of Birth *(Month, Day, Year)*: October 11, 1910
9. Birthplaca *(Stata or Foreign Country)*: Maryland

Usual Rastdence of Decedent

10a. Stata: Maryland
10b. County: n/a
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1 [X] Yas 2 [ ] No
10e. Street and Number: 4700 Harford Road
10f. Zip Code: 21214
10g. Citizen of What Country?: United States

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced
12. Was Decedent Evar in U.S. Armed Forces? 1 [ ] Yes 2 [X] No — If Yes, Give Yaar or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, atc.) 1 [ ] Yes 2 [X] No *Specify:*
14. Race - American Indian, Btack, Whita, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondery (0-12): 5 — College (1-4or 5+): 0
18a. Decedent's Usual Occupation *(Give kind of work dona during most of working life. DO NOT use retired)*: truck driver
16b. Kind of Business/Industry: city government

17. Fathar's Name *(First, Middle, Last)*: unknown
18. Mother's Neme *(First, Middle, Meiden Surname)*: unknown

19a. Informant's Name/Relationshtp *(Type, Print)*: Hugh James Melzer - son
19b. Meiling Address *(Street end Number or Rural Route Number, City or Town, State, Zip Code)*: 2628 Lehman Street, Baltimore, Maryland 21223

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removat from State 4 [ ] Donation 5 [ ] Other *(Specify)*
20b. Place of Disposition *(Nama of cemetery, crematory or other piece)*: Loudon Park Cemetery
Data: 4/6/01
20c. Location - City or Town, Stata: Baltimore, Maryland

21. Signature of Funaral Service Licensee: Ann Y. Zink
22. Nama and Address of Facility: Hubbard Funeral Home, Inc. 4107 Wilkens Avenue Baltimore, Maryland 21229

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feilure. List only one cause on aach line.

Approximate Interval Between Onset and Death

Immediata Cause (Finat disease or condition resulting in death): a. Pneumonia
Due to (or as a consequence ot):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
b. Due to (or as a consequence of):
c. Due to (or as a consequance of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. **Did tobacco use contributa to the causa of death?** 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy tindings available prior to completion ot causa of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medicat examiner? 1 [ ] Yes 2 [X] No
26. Place of Death *(Check only one)*: Hospitel: 1 [X] Inpatient 2 [ ] ER/Outpetient 3 [ ] DOA — Other: 4 [ ] Nursing Home 5 [ ] Residence 8 [ ] Other *(Specify)*

27. Mannar of Death: 1 [ ] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homlcide 5 [ ] Pending investigation 6 [ ] Could not be determtned
28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Ptece of Injury - At home, farm, street, fectory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 [X] **Certifying Physician:** To the best of my knowledge, deeth occurred at the time, date and place, end due to the cause(s) and mannar as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: John Schmitter MD
29c. License number: P 14137
29d. Date signed *(Month, Day, Year)*: April 3, 2001

30. Name and address of person who completed causa of death (Item 23a) (Type, Print): John Schmitter Good Samaritan Hospital 5601 Loch Raven Blvd. Baltimore, MD 21239

State Registrar

31. Date filed *(Month, Day, Year)*: APR 05 2001
32. Registrar's Signature: Geneva G Sparks

ORIGINAL

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 10402

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: ELEANOR WOODSON O'NEIL
2. Date of Death Month / Day / Year: 04-02-2001
3. Time of Death: 4 45 AM
4a. Facility Name *(If not institution, give street and number)*: 1302 JOHN STREET
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 579-28-0759
6. Sex: 1☐ M 2☑ F
7. Age *(In yrs. last birthday)*: 75 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: 01-16-1926
9. Birthplace *(State or Foreign Country)*: DC

Usual Residence of Decedent

10a. State: MD
10b. County: N/A
10c. City, Town or Location: BALTIMORE
10d. Inside City Limits: 1☑ Yes 2☐ No
10e. Street and Number: 1302 JOHN STREET
10f. Zip Code: 21217
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☐ Widowed 4☑ Divorced
12. Wes Decedent Ever in U.S. Armed Forces?: 1☐ Yes 2☑ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☑ No *Specify:*
14. Race - American Indien, Black, White, etc. *Specify:* WHITE

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12TH GRADE; College (1-4or 5+): 2 YRS
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: REALTOR
16b. Kind of Business/Industry: REAL ESTATE

17. Father's Name *(First, Middle, Lest)*: ALBERT WOODSON
18. Mother's Name *(First, Middle, Meiden Sumame)*: MARGARET BAKER

19a. Informant's Name/Reletionship *(Type, Print)*: COURTNEY O'NEIL (DAUGHTER)
19b. Mailing Address *(Street and Number or Rurel Route Number, City or Town, State, Zip Code)*: 5500 HOME RUN PKWY. #807, ALEXANDRIA, VA 22304

20a. Method of Disposition: 1☐ Burial 2☑ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other piece)*: METRO CREMATORY
Date: 04.05.01
20c. Location - City or Town, State: BALTO. MD

21. Signature of Funeral Service Licensee: ▶ Daughn C [illegible]
22. Name and Address of Facility: CREMATION SERVICES 5151 BALTO. NATL. PIKE, BALTO. MD. 21229

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Intervel Between Onset and Death

Immediete Ceuse (Final disease or condition resulting in death): a. Metastatic Adenocarcinoma

Due to (or es a consequence of):

Sequentiaily list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b.
Due to (or as a consequenca of):
c.
Due to (or as a consequenca of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?: 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

24a. Was an autopsy performed?: 1☑ Yes 2☐ No
24b. Were autopsy findings available prior to completion of cause of death?: 1☐ Yes 2☑ No

25. Was case referred to medical examiner?: 1☐ Yes 2☑ No
26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☑ Residenca 6☐ Other *(Specify)*

27. Manner of Death: 1☑ Naturat 2☐ Accident 3☐ Sulcide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined
28a. Date of Injury *(Month, Dey Year)*
28b. Time of Injury
28c. Injury at Work?: 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Ptece of tnjury - At home, ferm, street, fectory, office building, etc. *(Specify)*
28f. Location *(Street end Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☑ **Certifying Physician:** To the best of my knowledge, deeth occurred at the time, dete and place, end due to the cause(s) end manner as stated. 2☐ **Medical Examiner:** On the basis of examinetion end/or investigetion, in my opinion, death occurred at the time, date and placa, end due to the cause(s) end menner stated.

29b. Signeture and title of certifier: ▶ Katherine Tkaczuk MD
29c. License number: D36146
29d. Date signed *(Month, Day, Year)*: 4/3/2001

30. Nama and address of person who completed cause of death (Item 23a) (Type, Print): Univ. of Maryland Cancer Ctr, 22 S Greene St, Baltimore MD 21201

State Registrar

31. Dete filed *(Month, Dey, Year)*: APR 0 5 2001
32. Registrar's Signature: Penny D Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

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To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

4/8/10

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 10403

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
Frances Theresa Reed	April 4, 2001	12:40 AM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Ridgeway Manor Nursing Home	Catonsville	Baltimore

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
219-28-2347	1☐M 2☒F	96 Yrs.			09/20/1904	Pennsylvania

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Baltimore	Edmondson Heights	1☐Yes 2☒No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
1432 Kirkwood Road	21207	U.S.A.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Rece - American Indian, Black, White, etc.
1☒Never Married 2☐Married 3☐Widowed 4☐Divorced	1☐Yes 2☒No If Yes, Give Year or Detes:	1☐Yes 2☒No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
	6	Nursing Professor	Teaching

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Charles Francis Reed	Dora Euphemia Shulley

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code)
Cecelia Zitkus / Friend	1432 Kirkwood Road Baltimore, Maryland 21207

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, cremetory or other piece)	Dete	20c. Location - City or Town, Stete
1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	St. Mary's Cemetery	04/07/2001	Fairfield, Pennsylvania

21. Signature of Funeral Service Licensee	22. Name end Address of Facility
▶ David J. Weber	David J. Weber Funeral Homes PA 5311 Edmondson Avenue Baltimore, Maryland 21229

Physician /Medical Examiner

23a. Part1. Enter the disease or complications thet caused the death. Do not enter the mode of dying, such es cardiec or respiretory arrest, shock, or heart tailure. List *only one* cause *on* each line.

		Approximate Interval Between Onsel and Death
Immediate Cause (Final disease or condition resulting in death)	a. Respiratory Failure	1 week
Sequentially list conditions, if any, leading to immediete cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last	b. Due to (or as e consequence of): Acute Bronchitis	2 weeks
	c. Due to (or as a consequence of): Chronic Bronchitis	many years
	d. Due to (or as e consequence of):	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month Day Year
1☐Yes 2☒No 9☐Unknown	1☐Live birth 2☐Fetel deeth 3☐Ectopic pregnancy 4☐Pregnant et time of deeth 5☐Other (specify) 9☐Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?	24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐Yes 2☐No 3☐Probebly 4☐Unknown	1☐Yes 2☒No	1☐Yes 2☐No

25. Wes case referred to medical examiner?	26. Place of Death (Check only one)	
1☐Yes 2☒No	Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA	Other: 4☒Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury el Work?	28d. Describe how injury occurred
1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined		M	1☐Yes 2☐No	
	28e. Place of Injury - At home, ferm, street, fectory, offica building, etc. (Specify)		28f. Location (Street and Number or Rurel Route Number, City or Town, State)	

29a. Certifier (Check only one)
1☒ **Certifying Physician:** To the best of my knowledge, death occurred el the time, date and place, and due to the cause(s) end menner as steted.
2☐ **Medical Examiner:** On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, date and piece, and due to the cause(s) and manner stated.

29b. Signature end title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ Geetma Raja MD	D27541	April 5, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
GEETMA RAJA, 4367 Hollins Ferry Rd, Baltimore MD-21227

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
APR 05 2001	▶ Bruce G. Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification; To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No: 2001 10404

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)		2. Date of Death (Month, Day, Year)	3. Time of Death
KARL	ROSORIUS	Apr 1, 2001	3:15 P M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Catonsville Commons	Catonsville	Baltimore

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
218-03-8577	1☒M 2☐F	87 Yrs.			Feb 17, 1914	Maryland

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Anne Arundel	Odenton	1☐Yes 2☒No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
1340 Huntover Drive	21113	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐Never Married 2☐Married 3☒Widowed 4☐Divorced	1☒Yes 2☐No If Yes, Give Year or Dates: WW 2	1☐Yes 2☒No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
8	0	Postal Employee	US Government

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Charles Rosorius	Dorothea Link

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Donna Cox (Granddaughter)	1340 Huntover Dr., Odenton, Md. 21113

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	Loudon Park Cemetery	4/3/2001	Baltimore, Maryland

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
Kevin E Ecker	McCully-Polyniak Funeral Home, P.A. 237 E. Patapsco Ave., Balto., Md. 21225-1856

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. AS CVD	Yrs
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of): CHF	Yrs.
	c. Due to (or as a consequence of):	
	d. Due to (or as a consequence of):	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery (Month, Day, Year)
1☐Yes 2☒No 9☐Unknown	1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

End Stage Renal Disease

23e. Did tobacco use contribute to the cause of death?	24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐Yes 2☐No 3☐Probably 4☒Unknown	1☐Yes 2☒No	1☐Yes 2☒No

Medical Certification; To Be Completed by Physician/Medical Examiner

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐Yes 2☒No	Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA	Other: 4☒Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined		M	1☐Yes 2☐No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
Attending MD	D36942	April 3, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
B. TURAKHIA, MD. 1009, Frederick Rd. Catonsville, MD 21228

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
APR 05 2001	Received G Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

ADMEND ITEM: #19A PER F.H. G794 4-5-01 WR. *Certificate of Death* Reg. No: 2001 10405

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)			2. Date of Death Month Day Year	3. Time of Death
GERTRUDE		ROSS	APRIL 1, 2001	4:30 PM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
HOLY CROSS HOSPITAL	SILVER SPRING	MONTGOMERY

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
219-05-0036	1☐ M 2☒ F	84 Yrs.			JAN.7,1917	MD

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	MONTGOMERY	GAITHERSBURG	1☐ Yes 2☒ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
16516 ROUNDABOUT DRIVE	20878	U.S.A.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced	1☐ Yes 2☒ No If Yes, Give Year or Dates:	1☐ Yes 2☒ No Specify:	Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementery/Secondary (0-12)	College (1-4or 5+)		
12		PUNCH CARD OPERATOR	FEDERAL GOVERNMENT

17. Father's Name (First, Middle, Last)		18. Mother's Name (First, Middle, Maiden Surname)		
PAUL	COHEN	IDA	ESTHER	SACHS

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
~~GERALD GALLUN-SON~~ GERALD GALLUM - SON	16516 ROUNDABOUT DRIVE - GAITHERSBURG, MD 20878

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, cremetory or other piece)	Date	20c. Location - City or Town, State
1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)	BETH JACOB ANSHE VESHEAR	4/4/01	ROSEDALE, MD

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ Robert Levinson	SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. FATAL ARRYTHMIA	
	Due to (or as a consequence of):	
	b. SICK SINUS SYNDROME	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of):	
	c. ATHEROSCLEROTIC CARDIOVASCULAR DISEASE	
	Due to (or as a consequence of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

DEMENTIA, ALZHEIMER'S TYPE

23b. **Did tobacco use contribute to the cause of death?** 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐ Yes 2☒ No	1☐ Yes 2☐ No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐ Yes 2☒ No	Hospital: 1☐ Inpatient 2☒ ER/Outpatient 3☐ DOA	Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined		M	1☐ Yes 2☐ No	
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ Gail G. Porat MD	D46101	4/1/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

8700 GEORGIA AVENUE - SILVER SPRING, MD 20910

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
APR 05 2001	▶ Bernard G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the **Physician or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death. To the **Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 10406

Rogers, Jake

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Jake Ernest Rogers

2. Date of Death (Month, Day, Year): April 2, 2001

3. Time of Death: 2:00 PM

4a. Facility Name *(If not institution, give street and number)*: Franklin Square Hospital Center

4b. City, Town, or Location of Death: Rosedale

4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 238-30-5608

6. Sex: 1☒ M 2☐ F

7. Age *(In yrs. last birthday)*: 76 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: 10/24/1924

9. Birthplace *(State or Foreign Country)*: North Carolina

Usual Residence of Decedent

10a. State: Maryland

10b. County: Baltimore

10c. City, Town or Location: Essex

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 341 StillWater Road

10f. Zip Code: 21221

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 1☐ Yes 2☒ No Specify:

14. Race - Americen Indian, Black, White, etc. Specify: White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 10 / College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT usa retired)*: Carpenter

16b. Kind of Business/Industry: Construction

17. Father's Neme *(First, Middle, Last)*: Jake Coy Rogers

18. Mother'a Neme *(First, Middle, Maiden Sumeme)*: Eula Miller

19a. Informant's Name/Reletionship *(Type, Print)*: Maude A. Rogers (wife)

19b. Mailing Address *(Street end Number or Rural Route Number, City or Town, State, Zip Code)*: 341 Stillwater Road, Essex, Maryland 21221

20a. Method of Disposition: 1☒ Burial 2☐ Cramation 3☐ Ramoval from Stata 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, cremetory or other piece)*: Holly Hill Mem. Gardens

Date: 4/5/2001

20c. Location - City or Town, Stata: Baltimore, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility: Bruzdzinski Funeral Home, P.A. 1407 Old Eastern Avenue, Essex, Maryland 21221

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Finat disease or condition resulting in death) a.	End stage schemic cardiomyopathy	8 months
Due to (or as a consequence of): b.	Myocardial infarction	14 days
Sequentially list conditions, if any, leading to immediete ceuse. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Last — Due to (or as a consequence of): c.	Coronary artery disease	
d.		

Part II. **Other significant conditiona** contributing to death but not resulting in the underlying ceuse given in Part I.: Pneumonia

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of ceuse of death? 1☐ Yes 2☐ No

25. Was case referred to medicet examiner? 1☐ Yes 2☑ No

26. Piece of Death *(Check only one)*: Hospital: 1☑ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Menner of Death: 1☑ Natural 2☐ Accident 3☐ Suicida 4☐ Homicida 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rurel Route Number, City or Town, Steta)*

29a. Certifier *(Check only one)*: 1☑ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of axamination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) and manner stated.

29b. Signature and title of certifier: Marco Zamora MD

29c. Licansa number: D40819

29d. Date signed *(Month, Day, Year)*: April 2, 2001

30. Name and address of person who completed ceuse of death (Item 23a) (Type, Print): Dr. Marco Zamora, MD, 9000 Frankin Square Drive, Baltimore, MD 21237

State Registrar

31. Date filed *(Month, Day, Year)*: APR 05 2001

32. Registrar's Signature: D. Sparks

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

DHMH 16 Rev 6/95

ORIGINAL

RKD

01-1786-510

UNPENDED 62101: ITEM# 1,23a,27,28a-f per ME G796 SS

MARZOQ

SHAMBAZZ

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar AMEND ITEM: #11 PER F.H. G793 4-5-01 WR

Certificate of Death

Reg. No. 2001 10407

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month / Day / Year	3. Time of Death
MARZUQ Asmar Shabazz	APRIL 1, 2001	8:46P. M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
2424 N.CALVERT STREET	BALTIMORE	

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
218-38-9749	1 X M 2 ☐ F	46 Yrs.			April 10, 1954	MD.

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	Baltimore	Baltimore	1 X Yes 2 ☐ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
2424 N. Calvert street	21218	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1 X Never Married 2 ☐ Married 3 ☐ Widowed 4 X Divorced	1 ☐ Yes 2 X No If Yes, Give Year or Dates:	1 ☐ Yes 2 X No Specify:	Specify: Black

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12th	3	WINDOW CLEANER	Self Employed

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
BERNARD ROBINSON	Shirley REED

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Eleanor Robinson (Sister)	7321 Gavin st. New Carrollton MD 20784

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	Delaney Valley Cem.	4/6/01	Timonium, MD

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ Leander M. Coles	TRI-STATE FLS 108 W. North Ave, Baltimore MD.

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Finet disease or condition resulting in death)	a. NARCOTIC INTOXICATION AND COCAINE USE	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of):	
	c. Due to (or as a consequence of):	
	d. Due to (or as a consequence of):	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month / Day / Year
1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) _____ 9 ☐ Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?	24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown	1 X Yes 2 ☐ No	1 X Yes 2 ☐ No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1 X Yes 2 ☐ No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA	Other: 4 ☐ Nursing Home 5 ☐ Residence 6 X Other (Specify) SCENE

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 X Could not be determined	found: 4-1-01	found: 8:35 PM	1 ☐ Yes 2 X No	unknown

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)
found: residence	2424 N. Calvert St., Baltimore, MD

Medical Certification; To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

29a. Certifier (Check only one) 1 ☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 X **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶	O.C.M.E.	APRIL 2,2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Mary Gardner M.D. 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
APR 05 2001	Sandra B Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 10408

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): LAVANDER SPRIGGS
2. Data of Death (Month, Day, Year): APRIL 1, 2001
3. Time of Death: 18:19
4a. Facility Name (If not institution, give street and number): ST. AGNES HEALTHCARE
4b. City, Town, or Location of Death: BALTIMORE
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 216-82-2491
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 39 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Data of Birth (Month, Day, Year): OCTOBER 5, 1961
9. Birthplace (State or Foreign Country): MARYLAND

Usual Residance of Decedent

10a. State: MARYLAND
10b. County: BALTIMORE
10c. City, Town or Location: RANDALLSTOWN
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 8417 DOWNEY DALE DRIVE
10f. Zip Code: 21133
10g. Citizan of What Country?: U.S.A.

11. Marital Status: 1 [X] Nevar Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Evar in U.S. Armed Forces? 1 [ ] Yas 2 [X] No If Yas, Giva Yaar or Datas:
13. Was Decedent of Hispanic Origin? (Specify Yas or No- If Yas, specify Cuban, Mexican, Puarto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: BLACK

15. Decedent's Education (Specify only highast grada completed): Elementary/Secondary (0-12): 11TH GRADE; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work dona during most of working life. DO NOT use retired): PAINTER
16b. Kind of Business/Industry: SELF EMPLOYED

17. Fathar's Nema (First, Middle, Last): MELVIN SPRIGGS
18. Mothar's Nama (First, Middle, Maiden Surname): LONNIE BOYD

19a. Informent's Neme/Ralationship (Type, Print): LEMUEL SPRIGGS (BROTHER)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 8417 DOWNEY DALE DR., RANDALLSTOWN, MD 21133

20a. Mathod of Disposition: 1 [ ] Burial 2 [X] Cramation 3 [ ] Ramoval from State 4 [ ] Donation 5 [ ] Othar (Specify)
20b. Placa of Disposition (Nama of cemetery, crematory or othar placa): METRO CREMATORY
Data: 04-04-2001
20c. Location - City or Town, State: CATONSVILLE, MARYLAND

21. Signature of Funaral Service Licensee: ▶ Joseph H. Brown
22. Nama and Addrass of Facility: JOSEPH H. BROWN JR. FUNERAL HOME 2140 N. FULTON AVENUE, BALTIMORE, MD 21217

Physician /Medical Examiner

23a. Part1. Entar tha diseasa, or complications that caused tha death. Do not antar tha mode of dying, such as cardiac or raspiratory arrest, shock, or haart failura. List only one cause on aach lina.

Approximate Intarval Batween Onset and Death

Immediata Causa (Final diseasa or condition resulting in death): a. acquired immune deficiency syndrome — years

Dua to (or as a consequanca of):

Sequantially list conditions, if any, leading to immediata causa. Entar Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b.
Dua to (or as a consequanca of):
c.
Dua to (or as a consequanca of):
d.

Part II. **Other significant conditions** contributing to death but not rasulting in tha underlying causa given in Part I.: hepatitis B & C; necrotizing methicillin resistant Staph aureus empyema

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yas 2 [X] No
24b. Wara autopsy findings available prior to completion of cause of death? 1 [ ] Yas 2 [ ] No

25. Was case referred to medical examinar? 1 [ ] Yas 2 [X] No

26. Placa of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [X] ER/Outpatient 3 [ ] DOA; Other: 4 [ ] Nursing Hama 5 [ ] Rasidence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accidant 3 [ ] Suicide 4 [ ] Homicida 5 [ ] Pending Investigation 6 [ ] Could not be datarmined

28a. Place of Injury - At hama, farm, straat, factory, office building, atc. (Specify):
28b. Tima of Injury: M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Dascribe how injury occurred:
28e. Data of Injury (Month, Day Year):
28f. Location (Street and Number or Rural Route Number, City or Town, State):

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To tha best of my knowledga, daath occurred at tha tima, date and place, end due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On tha basis of axamination and/or investigation, in my opinion, daath occurred at tha tima, data and place, and dua to tha cause(s) and mannar stated.

29b. Signature and title of certifier: Jeannine Saunders MD
29c. License number: D33061
29d. Data signed (Month, Day, Year): April 1, 2001

30. Nama and address of person who completed causa of death (Item 23a) (Type, Print): Jeannine Saunders St Agnes Healthcare Baltimore 21229

State Registrar

31. Data filed (Month, Day, Year): APR 05 2001
32. Registrar's Signatura: ▶ Geneva G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

LAVENDER, SPRIGGS

Pg 2

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No: 2001 10409

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)			2. Date of Death Month / Day / Year	3. Time of Death
JUDY	ANN	TRUETT	APRIL 3, 2001	12:20 MPM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Saint Joseph Medical Center	Towson	Baltimore

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
219-50-4635	1☐ M 2☒ F	52 Yrs.			MAR. 1, 1949	VIRGINIA

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MARYLAND	ANNE ARUNDEL	LINTHICUM	1☐ Yes 2☒ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
213 SYCAMORE ROAD	21090	U.S.A.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced	1☐ Yes 2☒ No If Yes, Give Year or Dates:	1☐ Yes 2☒ No Specify:	Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
	2	HOMEMAKER	OWN HOME

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
CHARLES CONGO	PAULINE HENSLEY

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
DANIEL JOSEPH TRUETT (HUSBAND)	213 SYCAMORE ROAD, LINTHICUM, MARYLAND 21090

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)	CEDAR HILL CEMETERY	4/7/2001	BROOKLYN PARK, MD.

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
	SINGLETON FUNERAL HOME, P.A., 1 SECOND AVENUE, S.W., GLEN BURNIE, MD. 21061

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. VENTRICULAR FIBRILLATION	2 WEEKS
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of): b. ISCHEMIC CARDIAC DISEASE	
	Due to (or as a consequence of): c.	
	Due to (or as e consequence of): d.	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivary Month / Day / Year
1☐ Yes 2☒ No 9☐ Unknown	1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) _____ 9☐ Unknown	

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

INTRACRANIAL HEMORRHAGE

ACUTE RENAL FAILURE

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐ Yes 2☒ No	1☐ Yes 2☒ No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐ Yes 2☒ No	Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA	Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined		M	1☐ Yes 2☐ No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
H Neal Reynolds	D 27103	4/3/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

HOWARD NEAL REYNOLDS, M.D., 7601 OSLER DRIVE, TOWSON, MARYLAND 21204

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
APR 05 2001	Bonnie G Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23e or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 10410

Physician /Medical Examiner

1. Decadant's Nama (First, Middla, Last): THERESA THOMAS
2. Data of Daath — Month: MARCH Day: 28 Yaar: 2001
3. Tima of Death: 9:30pm
4a. Facility Nama (If not institution, giva straat and numbar): LORRAINE FRANKFORD
4b. City, Town, or Location of Daath: Baltimore
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 220-30-5883
6. Sax: 1☐ M 2☒ F
7. Aga (In yrs. last birthday): 75 Yrs. — If Under 1 Yaar: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Data of Birth (Month, Day, Yaar): August 18 1925
9. Birthplaca (Stata or Foraign Country): UNKNOWN

Usual Residence of Decedent

10a. Stata: MD
10b. County: Baltimore
10c. City, Town or Location: Baltimore
10d. Insida City Limits: 1☒ Yas 2☐ No
10a. Straat and Numbar: 5009 FRANKFORD AVE
10f. Zip Coda: 21206
10g. Citizan of What Country?: USA

11. Marital Status: 1☒ Never Marriad 2☐ Marriad 3☐ Widowed 4☐ Divorced
12. Was Dacedant Evar in U.S. Armed Forcas? 1☐ Yas 2☐ No — If Yas, Giva Yaar or Datas: UKN
13. Was Dacedant of Hispanic Origin? (Specify Yas or No- If Yas, specify Cuban, Maxican, Puarto Rican, atc.): 1☐ Yas 2☒ No Specify:
14. Raca - Amarican Indian, Black, Whita, atc. Specify: BLACK

15. Dacedant's Education (Spacify only highast grada complatad): Elamantary/Sacondary (0-12): UKN — Collaga (1-4or 5+): —
16a. Decedant's Usual Occupation (Giva kind of work dona during most of working life. DO NOT usa ratirad): MAINTENANCE
16b. Kind of Businass/Industry: HOSPITAL WORK

17. Fathar's Nama (First, Middla, Last): UNKNOWN
18. Mothar's Nama (First, Middla, Maidan Surnama): UNKNOWN

19a. Intorment's Nama/Relationship (Type, Print): LORRAINE CHAPMAN (FRIEND)
19b. Mailing Address (Street and Number or Rural Routa Numbar, City or Town, Stata, Zip Coda): 902 N. BROADWAY BALTIMORE MD 21205

20a. Method of Disposition: 1☒ Burial 2☐ Cramation 3☐ Ramoval from Stata 4☐ Donation 5☐ Othar (Specify)
20b. Placa of Disposition (Nama of camatary, cramatory or othar placa): VOSHELL CEMETERY — Data: 4/10/01
20c. Location - City or Town, Stata: BALTIMORE MD
21. Signature of Funaral Sarvica Licansaa: LEANDER M. COLES
22. Nama and Addrass of Facility: TRI-STATE #15 108 W. NORTH AVE., BALTIMORE MD.

Physician /Medical Examiner

23a. Part I. Entar tha disaasa, or complications that causad tha daath. Do not antar tha moda of dying, such as cardiac or raspiratory arrast, shock, or haart failura. List only ona causa on aach lina.

Approximata Intarval Batwaan Onsat and Death

Immadiata Cause (Final disaasa or condition rasulting in daath)
a. CACHEXIA — MONTHS

Dua to (or as a consaquanca of):
b. ADVANCED ALZHEIMERS — YEARS

Saquantially list conditions, if any, laading to immadiata causa. Entar Undarlying Causa (Diseasa or injury that initiatad avants rasulting in daath) Last
c.

Dua to (or as a consaquanca of):
d.

Part II. **Other significant conditions** contributing to death but not rasulting in tha undarlying causa givan in Part I.: ASCVD; SPINAL STENOSIS & LE WEAKNESS; SEVERE DJD

23b. Did tobacco use contribute to the cause of death? 1☐ Yas 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performad? 1☐ Yas 2☒ No
24b. Were autopsy findings availabla prior to complation of causa of daath? 1☐ Yas 2☐ No

25. Was casa rafarrad to madical axaminar? 1☐ Yas 2☒ No

26. Placa of Death (Check only one): Hospital: 1☐ Inpatiant 2☐ ER/Outpatiant 3☐ DOA — Othar: 4☒ Nursing Home 5☐ Rasidance 6☐ Othar (Specify)

27. Mannar of Death: 1☒ Natural 2☐ Accidant 3☐ Suicida 4☐ Homicida 5☐ Pending invastigation 6☐ Could not be determinad

28a. Place of Injury - At homa, farm, street, factory, office building, atc. (Specify)
28b. Tima of Injury
28c. Injury at Work? 1☐ Yas 2☐ No
28d. Describa how injury occurrad
28a. Location (Street and Number or Rural Routa Number, City or Town, Stata)

29a. Certifier (Check only one): 1☒ **Certifying Physician**: To tha best of my knowladga, death occurrad at tha tima, data and place, and dua to tha causa(s) and mannar as stated. 2☐ **Madical Examiner**: On tha basis of axamination and/or investigation, in my opinion, daath occurrad at tha time, data and place, and dua to tha causa(s) and mannar stated.

29b. Signature and title of certifier: MD
29c. Licansa number: D41291
29d. Data signed (Month, Day, Yaar): 4/3/01

30. Nama and addrass of parson who complatad causa of daath (Item 23a) (Type, Print): JONATHAN GITTLE 21 CROSSROADS DR. #330 OWINGS MILLS 21117

State Registrar

31. Data filad (Month, Day, Yaar): APR 05 2001
32. Registrar's Signatura: [signature]

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

George D. Williams
01-1549=510
UNKNOWN 01-063
JVW

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No 2001 10411

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): George D. Williams
2. Date of Death Month/Day/Year: MARCH 20, 2001
3. Time of Death: 02:04 AM
4a. Facility Name (If not institution, give street and number): 1500 SOUTH EUTAW STREET
4b. City, Town, or Location of Death: BALTIMORE
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 114-48-7950
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 46 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): November 15, 1954
9. Birthplace (State or Foreign Country): North Carolina

Usual Residence of Decedent

10a. State: N.Y.
10b. County: Bronx
10c. City, Town or Location: New York
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 535 Havemyer Avenue
10f. Zip Code: 10457
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [ ] Widowed 4 [X] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Disabled
16b. Kind of Business/Industry:

17. Father's Name (First, Middle, Last): James Williams
18. Mother's Name (First, Middle, Maiden Surname): Marylou Brown

19a. Informant's Name/Relationship (Type, Print): Parcell Williams / Brother
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 535 Havemeyer Avenue Bronx NY 10457

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Calverton National Cem | Date: April 10, 2001
20c. Location - City or Town, State: Calverton, NY

21. Signature of Funeral Service Licensee: Cyllenior Filipousis
22. Name and Address of Facility: New York Mortuary Svc 2242 1st Avenue NY NY 10029

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. BLUNT FORCE INJURIES OF HEAD

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. Due to (or as a consequence of):

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1 [ ] Yes 2 [ ] No 9 [ ] Unknown
23c. If yes, outcome of pregnancy: 1 [ ] Live birth 2 [ ] Fetal death 3 [ ] Ectopic pregnancy 4 [ ] Pregnant at time of death 5 [ ] Other (specify) 9 [ ] Unknown
23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown
24a. Was an autopsy performed? 1 [X] Yes 2 [ ] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [X] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [X] Yes 2 [ ] No
28. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [X] Other (Specify) SCENE

27. Manner of Death: 1 [ ] Natural 2 [ ] Accident 3 [ ] Suicide 4 [X] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of injury (Month, Day Year): 3/20/01 FOUND
28b. Time of Injury: FOUND A M
28c. Injury at Work? 1 [ ] Yes 2 [X] No
28d. Describe how injury occurred: SUBJECT WAS ASSAULTED
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify): UNKNOWN
28f. Location (Street and Number or Rural Route Number, City or Town, State): 1500 SOUTH EUTAW ST, BALTIMORE, MD

29a. Certifier (Check only one): 1 [ ] Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [X] Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, end due to the cause(s) and manner stated.

29b. Signature and title of certifier: M.D.
29c. License number: O.C.M.E.
29d. Date signed (Month, Day, Year): MARCH 20, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Mary G. Ripple, M.D. 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year): APR 05 2001
32. Registrar's Signature: [signature]

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification; To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 10412

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)			2. Date of Death Month Day Yeer	3. Time of Death
Betty	Sue	Abell	MARCH 27, 2001	5:00PM M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
St. Mary's Hospital	Leonardtown	St. Mary's

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year Months	If Under 1 Year Days	If Under 24 Hrs. Hours	If Under 24 Hrs. Min.	8. Date of Birth (Month, Day, Yeer)	9. Birthplace (State or Foreign Country)
250-56-7766	1☐ M 2☒ F	64 Yrs.					Jan.23, 1937	South Carolina

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	St. Mary's	Valley Lee	1☐ Yes 2☒ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
43648 Abell Farm Way	20692	U S A

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced	1☐ Yes 2☒ No If Yes, Give Year or Dates:	1☐ Yes 2☒ No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
9th grade		Mail Courier	County Government

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Archie B. Page	Dorothy P. Hicks

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Douglas W. Abell (Son)	43648 Abell Farm Way, Valley Lee, Maryland 20692

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, cremetory or other piece)	Date	20c. Location - City or Town, State
1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)	St. George Episcopal	3/31/2001	Valley Lee, Maryland

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
Edward N. Brinsfield, JR. M00052	Brinsfield Funeral Home, P.A. P.O. Box 279, Leonardtown, Maryland 20650

Physician /Medical Examiner

Medical Certification; To Be Completed by Physician/Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. RESPIRATORY FAILURE

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. LUNG CANCER

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery
1☐ Yes 2☒ No 9☐ Unknown	1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) 9☐ Unknown	Month Day Year

Part II. **Other significant condtions** contributing to death but not resulting in the underlying cause given in Part I.

HYPERCALCEMIA

23e. Did tobacco use contribute to the cause of death? 1☑ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐ Yes 2☒ No	1☐ Yes 2☐ No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐ Yes 2☒ No	Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA	Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Yeer)	28b. Time of Injury	26c. Injury at Work?	28d. Describe how injury occurred
1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined		M	1☐ Yes 2☐ No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
	D56096	3/29/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DR. RAJBINDER S. GILL HOLLYWOOD,MD. 20636

State Registrar

31. Date filed (Month, Day, Yeer)	32. Registrar's Signature
MAR 29 2001	

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

NAME; BETTY SUE ABELL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 10413

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: LEROY ENOCH AMBUSH
2. Date of Death (Month, Day, Year): March 20, 2001
3. Time of Death: 5:08AM
4a. Facility Name *(If not institution, give street and number)*: HOLY CROSS HOSPITAL
4b. City, Town, or Location of Death: Silver Spring
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 220 50 8984
6. Sex: 1 [X] M 2 [ ] F
7. Age *(In yrs. last birthday)*: 50 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: 04 02 1950
9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Md
10b. County: Montgomery
10c. City, Town or Location: Boyds
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 17310 Barnsville Road
10f. Zip Code: 20841
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No — If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 [ ] Yes 2 [X] No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* Black

15. Decedent's Education *(Specify only highest grade completed)*: Elementery/Secondery (0-12) / College (1-4or 5+): 1
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Landscaper
16b. Kind of Business/Industry: County Gouv't

17. Father's Name *(First, Middle, Last)*: Leroy F. Ambush
18. Mother's Name *(First, Middle, Maiden Surname)*: Eleanor Hayes

19a. Informant's Name/Relationship *(Type, Print)*: Eleanor H. Robinson
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 15118 Callohan Count Silver Spring, Maryland 20906

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: St Marks United Meth Church Cemetery — Date: 3/24/01
20c. Location - City or Town, State: Boyds, Maryland

21. Signature of Funeral Service Licensee: Ruth C. Hall
22. Name and Address of Facility: HALL BROTHERS FUNERAL HOME 20001, 621 Florida Avenue, N.W., Washington D.C.

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Arrhythmia
Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Chronic renal failure

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [ ] No — No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No
26. Place of Death *(Check only one)*: Hospital: 1 [ ] Inpatient 2 [X] ER/Outpatient 3 [ ] DOA — Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other *(Specify)*
27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined
28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: [signature]
29c. License number: D 42878
29d. Date signed *(Month, Day, Year)*: March 20, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Gul Chablani 11119 Rockville Pike Suite 316, Rockville, Md 20852

State Registrar

31. Date filed *(Month, Day, Year)*: MAR 23 2001
32. Registrar's Signature: [signature]

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 10414

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Jeanette Juanita Allgood
2. Date of Death Month Day Year: March 8, 2001
3. Time of Death: 11:30 A M
4a. Facility Name *(If not institution, give street and number)*: Mariner Health Center
4b. City, Town, or Location of Death: Laurel
4c. County of Death: Prince Georges

Funeral Director

5. Social Security Number: 579-70-6958
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 72 Yrs.
If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: April 19, 1928
9. Birthplace *(State or Foreign Country)*: Washington DC

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: MD
10b. County: Prince Georges
10c. City, Town or Location: Severn
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 8035 Laketown Court
10f. Zip Code: 21114
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* Black

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12; College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Home Maker
16b. Kind of Business/Industry: Private

17. Father's Name *(First, Middle, Last)*: Wyman Williams
18. Mother's Name *(First, Middle, Meiden Surname)*: Annabelle Strange

19a. Informant's Name/Relationship *(Type, Print)*: Wyman P. Allgood- Son
19b. Mailing Address *(Street and Number or Rurel Route Number, City or Town, State, Zip Code)*: 6203 Osborn Road; Landover MD 20785

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, cremetory or other place)*: Ft. Lincoln Cemetery
Date: 3-14-2001
20c. Location - City or Town, State: Brentwood, Maryland

21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: Ft. Lincoln Funeral Home 3401 Bladensburg Rd Brentwood MD 20722

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Neoplasm uterus — Approximate Interval: 6 months

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. Due to (or as a consequence of):
c. Due to (or as e consequence of):
d. Due to (or as a consequence of):

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐ Yes 2☒ No 9☐ Unknown
23c. If yes, outcome of pregnancy: 1☐ Live birth 2☐ Fetel death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other *(specify)* 9☐ Unknown
23d. Date of delivery Month Dey Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobecco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probebly 4☒ Unknown

24e. Was en autopsy performed? 1☐ Yes 2☒ No
24b. Were eutopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

28. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☒ Nursing Home 5☐ Residenca 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, offica building, etc. *(Specify)*
28f. Location *(Street end Number or Rurel Route Number, City or Town, State)*

Medical Certification; To Be Completed by Physician/Medical Examiner

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as steted. 2☐ **Medical Examiner:** On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date end place, end due to the cause(s) and manner stated.

29b. Signature and title of certifier: Andrew Kunduat M.D.
29c. Licanse number: D36716
29d. Date signed *(Month, Day, Year)*: March 13, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Andrew Kunduat, M.D. 8317 Cherrylane Laurel MD 20707

State Registrar

31. Date filed *(Month, Day, Year)*: MAR 2 0 2001
32. Registrar's Signature: [signature]

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

LAWRENCE AUSTIN
01-1688-033
JVW

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar UNPENDED 080801: ITEMS#1,23a,27 per ME G798 SS

Certificate of Death

Reg. No. 2001 10415

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Data of Death Month Day Yaar	3. Tima of Daath
Lawrence Austin Sr.	MARCH 27,2001	02:40A M

4a. Facility Nama (If not institution, giva street and number)	4b. City, Town, or Location of Daath	4c. County of Death
6205 59th AVENUE	RIVERDALE	PRINCE GEORGE'S

Funeral Director

5. Social Security Number	6. Sax	7. Age (In yrs. last birthday)	If Undar 1 Year Months / Days	If Undar 24 Hrs. Hours / Min.	8. Data of Birth (Month, Day, Yaar)	9. Birthplace (State or Foraign Country)
217-42-1916	1☒M 2☐F	57 Yrs.			03-30-1943	Virginia

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Insida City Limits
MD	Prince Georges	Landover Hills	1☒Yes 2☐No

10e. Street and Number	10f. Zip Coda	10g. Citizan of What Country?
7100 Chesapeake Rd #201	20784	U.S.A.

11. Marital Status	12. Was Decedent Evar in U.S. Armed Forcas? If Yes, Give Yaer or Dates:	13. Was Decedant of Hispanic Origin? (Specify Yas or No- If Yes, specify Cuban, Maxican, Puarto Rican, atc.)	14. Race - Amarican Indian, Black, Whita, atc.
1☐Never Married 2☒Married 3☐Widowed 4☐Divorced	1☐Yes 2☒No	1☐Yas 2☒No Specify:	Specify: Black

15. Decedent's Education (Specify only highast grada completed)		16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT use retired)	16b. Kind of Businass/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12th		Custodian	Government

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Sumame)
Alfred Austin	Emma Parker

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Addrass (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code)
Ruth Austin/Wife	8207 Morningview Dr Gaithersburg, MD 20877

20a. Method of Disposition	20b. Place of Disposition (Nama of cemetery, cramatory or othar place)	Data	20c. Location - City or Town, Stata
1☐Burial 2☒Cremation 3☐Ramoval from Stata 4☐Donation 5☐Other (Specify)	Riverdale	4/3/2001	Riverdale, MD

21. Signature of Funeral Service Licensea ▶ [signature]

22. Name and Addrass of Facility J.B. Jenkins Funeral Home
7474 Landover Rd Landover, MD 20785

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23e or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Physician /Medical Examiner

23a. Part I. Enter the diseasa, or complicetions thet caused the deeth. Do not enter tha mode of dying, such as cardiac or raspiratory arrast, shock, or heart failura. List only one cause on each line.

Approximata Intarval Between Onsat and Death

Immediate Cause (Final disease or condition resulting in death)
a. HYPERTENSIVE ATHEROSCLEROTIC CARDIOVASCULAR DISEASE

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last
b.

Due to (or as a consequence of):
c.

Due to (or as a consequance of):
d.

IF FEMALE: 23b. Wes decedent pregnant in the past 12 months? 1☐Yes 2☐No 9☐Unknown	23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fatal daath 3☐Ectopic pregnancy 4☐Pregnent at time of death 5☐Othar (specify) 9☐Unknown	23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to daath but not rasulting in tha undarlying cause given in Part I.

23a. Did tobacco usa contributa to the cause of daath? 1☐Yas 2☐No 3☐Probably 4☒Unknown		
24a. Was an autopsy performed? 1☒Yas 2☐No	24b. Wara autopsy findings available prior to compliation of cause of daath? 1☒Yas 2☐No	

25. Was case referred to medical examiner? 1☒Yes 2☐No	26. Placa of Daath (Check only one) Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☐Rasidanca 6☒Othar (Specify) SCENE	
27. Manner of Death 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be datarmined	28a. Dete of Injury (Month, Day Year) / 28b. Time of Injury M / 28c. Injury at Work? 1☐Yas 2☐No	28d. Describe how injury occurred
	28a. Place of Injury - At homa, farm, street, factory, office building, etc. (Specify)	28f. Location (Streat and Numbar or Rural Route Numbar, City or Town, State)

Medical Certification; To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

29a. Certifier (Check only one) 1☐ **Certifying Physician:** To tha best of my knowledge, death occurred at tha time, dete and place, and dua to tha causa(s) and mannar as stated.
2☒ **Medical Examiner:** On tha basis of axamination and/or investigation, in my opinion, daath occurred at tha tima, data and place, and due to tha ceusa(s) and mannar stated.

29b. Signature and title of certifier	29c. Licensa number	29d. Data signed (Month, Day, Year)
▶ [signature]	O.C.M.E.	MARCH 27,2001

30. Name end address of person who completed cause of death (Item 23a) (Type, Print)
THEODORE McKenny 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Data filed (Month, Day, Yaar)	32. Registrar's Signature
APR 02 2001	▶ [signature]

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 10416

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Mary Heiberger Anselmo
2. Date of Death (Month, Day, Year): March 16, 2001
3. Time of Death: 3:00PM
4a. Facility Name *(If not institution, give street and number)*: Manor Care of Silver Spring
4b. City, Town, or Location of Death: Silver Spring
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 577-05-2623
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 86 Yrs. — If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: Dec. 22, 1914
9. Birthplace *(State or Foreign Country)*: Wash. D.C.

Usual Residence of Decedent

10a. State: Maryland
10b. County: Montgomery
10c. City, Town or Location: Silver Spring
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 1010 Briggs Chaney Road
10f. Zip Code: 20905
10g. Citizen of What Country?: United States
11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Evar in U.S. Armed Forces? 1☐ Yas 2☒ No If Yes, Give Yaar or Datas:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, Whita, atc. *Specify:* White
15. Decedent's Educaflon *(Specify only highast grade completed)*: Elementary/Secondary (0-12); College (1-4or 5+): 1
16a. Decedent's Usual Occupation *(Give kind of work done duning most of working life. DO NOT use retired)*: Homemaker
16b. Kind of Business/Industry: Home
17. Father's Name *(First, Middle, Last)*: Henry B. Heiberger
18. Mother's Neme *(First, Middle, Maiden Surname)*: Loretta Kiernan
19a. Informant's Name/Relationship *(Type, Print)*: Michael A. Anselmo/Husband
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 1010 Briggs Chaney Road Silver Spring, MD 20905
20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Gate of Heaven
Date: 3/20/01
20c. Location - City or Town, State: Silver Spring, MD
21. Signatura of Funaral Sarvice Licensee: Alan J. Powell
22. Nama and Address of Facility: Hines-Rinaldi Funeral Home, Inc. 11800 New Hampshire Ave Silver Spring, MD 20904

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the daath. Do not enter the moda of dying, such as cardiac or raspiratory arrest, shock, or heart failura. List only ona cause on each iine.

Approximate Interval Between Onset and Death

Immediata Cause (Final disaasa or condition resulting in death)
a. Pneumonia — 48 hours
Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated avents resulting in death) Last
b.
Due fo (or as a consequence of):
c.
Dua to (or as a consequance of):
d.

Part II. **Other significant conditiona** contributing to death but not resulting in the underlying cause given in Part I.: Insulin Dependent Diabetes; Hypertension; Organic Brain Syndrome

23b. Did tobacco use contribute to the cause of death? 1☐ Yea 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only ona)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☒ Nursing Home 5☐ Residence 8☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicida 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29e. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and menner as stated. 2☐ **Medical Examiner:** On tha basia of examination and/or investigation, in my opinion, daath occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier:
29c. License number: D25430
29d. Date signed *(Month, Day, Year)*: 03/19/01

30. Neme and address of person who completed cause of death (Item 23a) (Type, Print): John MARGOLIS MD 13952 Baltimore Ave, Laurel, MD 20707

State Registrar

31. Date filed *(Month, Day, Year)*: MAR 2 1 2001
32. Registrar's Signature: Bernice B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 10417

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Linwood J. Adams
2. Date of Death (Month, Day, Year): March 21, 2001
3. Time of Death: 3:00 am
4a. Facility Name (If not institution, give street and number): Mariner Health Care- Silver Spring
4b. City, Town, or Location of Death: Silver Spring
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 027-18-3256
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 75 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): July 6, 1925
9. Birthplace (State or Foreign Country): Massachusetts

Usual Residence of Decedent

10a. State: Maryland
10b. County: Montgomery
10c. City, Town or Location: Silver Spring
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 1107 Meurilee Lane
10f. Zip Code: 20901
10g. Citizen of What Country: USA

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: 1943-1945
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Office Machine Repairman
16b. Kind of Business/Industry: US Government

17. Father's Name (First, Middle, Last): Joseph Adams
18. Mother's Name (First, Middle, Maiden Surname): Domatilla Grady

19a. Informant's Name/Relationship (Type, Print): Arlene Lorane Adams/ Wife
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1107 Meurilee Lane, Silver Spring, MD 20901

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Parklawn Memorial Park | Date: Mar 26 2001
20c. Location - City or Town, State: Rockville, MD

21. Signature of Funeral Service Licensee: ▶ Dawn Marie Parker
22. Name and Address of Facility: Francis J. Collins Funeral Home, Inc. 500 University Blvd., W, Silver Spring, MD 20901

Physician /Medical Examiner

23a. Part I. Enter the Disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Prostate Cancer	3 years
	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b.	
	Due to (or as a consequence of):	
	c.	
	Due to (or as a consequence of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | Other: 4 [X] Nursing Home 5 [ ] Residence 8 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Barry Rosenbaum
29c. License number: D 09834
29d. Date signed (Month, Day, Year): March 21, 2001

30. Name and address of person who completed ceuse of death (Item 23a) (Type, Print): Barry Rosenbaum, MD 3720 Farragut Ave., Kensington, MD 20895

State Registrar

31. Date filed (Month, Day, Year): MAR 23 2001
32. Registrar's Signature: ▶ Geneva B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 | 0418

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Caroline Aubrey
2. Date of Death (Month, Day, Year): March 10, 2001
3. Time of Death: 5:00 AM
4a. Facility Name *(If not institution, give street and number)*: 8535 Abell Way
4b. City, Town, or Location of Death: Waldorf
4c. County of Death: Charles

Funeral Director

5. Social Security Number: 068-10-9292
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 86 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: March 5, 1915
9. Birthplace *(State or Foreign Country)*: New York

Usual Residence of Decedent

10a. State: New York
10b. County: Nassau
10c. City, Town or Location: Oceanside
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 2532 Harvey Ave.
10f. Zip Code: 11572
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indien, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 | College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Supervisior
16b. Kind of Business/Industry: Defense, Aerospace

17. Father's Name *(First, Middle, Last)*: Pasqual Sirianni
18. Mother's Name *(First, Middle, Maiden Sumeme)*: Amelia Madotta

19a. Informant's Neme/Relationship *(Type, Print)*: Barbara LaBeff/Niece
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 2532 Harvey Ave., Oceanside, NY 11572

20a. Method of Disposition: 1☒ Burial 2☐ Cremetion 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, cremetory or other pleca)*: Greenfield Cemetery | Date: Mar. 17,
20c. Location - City or Town, Stata: 01 Hempstead, NY

21. Signature of Funeral Service Licansee: ▶ Dennis Pelletier
22. Neme and Address of Facility: Metropolitan Funeral Service 5517 Vine St., Alexandria, VA 22310

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one ceuse on each line. | Approximate Interval Between Onset end Deeth

Immediate Cause (Final diseese or condition resulting in death): a. Cerebrovascular Disease
Due to (or as a consequence of):
Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
b. Due to (or es e consequence of):
c. Due fo (or as e consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☐ Residence 6☒ Other *(Specify)* Son's Residence

27. Menner of Death: 1☒ Natural 2☐ Accident 3☐ Sulcide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined
28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury M
28c. Injury et Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Pleca of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rurel Route Number, City or Town, Stete)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, dete and placa, and due to the cause(s) and manner es stated. 2☐ **Medical Examiner:** On the basis of examinetion and/or investigetion, in my opinion, deeth occurred at the time, dete and placa, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Mich A Leatherwood
29c. License number: D0021031
29d. Data signed *(Month, Day, Year)*: 3/16/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Michael A. Leatherwood, M.D. , 12070 Old Line Center, #202, Waldorf, MD 20602

State Registrar

31. Date filed *(Month, Day, Year)*: MAR 19 2001
32. Registrar's Signature: ▶ Donna G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

5 (10)

RKD

01-1547-510

LEWELLYN BOWEN

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 10419

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Lewellyn M. Bowen

2. Date of Death: Month MARCH Day 19, Year 2001

3. Time of Death: 6:24P. M

4a. Facility Name (If not institution, give street and number): SHOCK TRAUMA CENTER

4b. City, Town, or Location of Death: BALTIMORE CITY

4c. County of Death:

Funeral Director

5. Social Security Number: 411-56-9612

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 67 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): November 16, 1933

9. Birthplace (State or Foreign Country): North Carolina

Usual Residence of Decedent

10a. State: Delaware

10b. County: New Castle

10c. City, Town or Location: Newark

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 722 Art Lane

10f. Zip Code: 19713

10g. Citizen of Whel Country?: United States

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Rece - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): College (1-4or 5+): 5+

16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Teacher

18b. Kind of Business/Industry: Christina School District

17. Father's Name (First, Middle, Last): John Richard Murphy

18. Mother's Name (First, Middle, Maiden Surname): Sally Dickson

19a. Informant's Name/Relationship (Type, Print): Travis L. Bowen / Husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 722 Art Lane, Newark, Delaware 19713

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Snow Hill Cemetery

Date: March 24, 2001

20c. Location - City or Town, State: Snow Hill, North Carolina

21. Signature of Funeral Service Licensee:

22. Name and Address of Facility: Spicer-Mullikin Funeral Home, 121 West Park Place, Newark, Delaware 19711

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. MULTIPLE INJURIES

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1☐ Yes 2☒ No 9☐ Unknown

23c. If yes, outcome of pregnancy: 1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) 9☐ Unknown

23d. Date of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24e. Was an autopsy performed? 1☒ Yes 2☐ No

24b. Were autopsy findings available prior to completion of cause of death? 1☒ Yes 2☐ No

25. Was case referred to medical examiner? 1☒ Yes 2☐ No

28. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☒ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 8☐ Other (Specify)

27. Manner of Death: 1☐ Natural 2☒ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year): 3/19/01

28b. Time of Injury: 1113 M

28c. Injury at Work? 1☐ Yes 2☒ No

28d. Describe how injury occurred: PASSENGER IN AUTOMOBILE COLLISION

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify): INTERSTATE HIGHWAY

28f. Location (Street and Number or Rural Route Number, City or Town, State): INTERSTATE 95 AT MILE MARKER 105.4N, CECIL COUNTY, MD NORTH EAST

29a. Certifier (Check only one): 1☐ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☒ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: MD

29c. License number: O.C.M.E.

29d. Date signed (Month, Day, Year): MARCH 20, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): MARY G. RIPPLE, M.D. 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year): MAR 22 2001

32. Registrar's Signature: Gordon B. Sparks

DHMH 17 Rev 1/2001

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification; To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

10

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No: 2001 10420

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Thomas G. Brakeall

2. Date of Death: Month: March Day: 21 Year: 2001

3. Time of Death: 4:10 a.m.

4a. Facility Name (If not institution, give street and number): Sunbridge Care Center

4b. City, Town, or Location of Death: Elkton

4c. County of Death: Cecil

Funeral Director

5. Social Security Number: 214-07-3298

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 86 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Aug. 30, 1914

9. Birthplace (State or Foreign Country): Pennsylvania

Usual Residence of Decedent

10a. State: Maryland

10b. County: Cecil

10c. City, Town or Location: Rising Sun

10d. Inside City Limits: 1 [X] Yes 2 [ ] No

10e. Street and Number: 19 W. Cherry Street

10f. Zip Code: 21911

10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Owner/Operator

16b. Kind of Business/Industry: Retail Gasoline

17. Father's Name (First, Middle, Last): Edward Brakeall

18. Mother's Name (First, Middle, Maiden Surname): Mary Morse

19a. Informant's Name/Relationship (Type, Print): Marjorie W. Brakeall/Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): PO Box 386, Rising Sun, MD 21911

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, cremetory or other place): Brookview Cemetery

Date: 3-24-01

20c. Location - City or Town, State: Rising Sun, Maryland

21. Signature of Funeral Service Licensee: Richard L. Goodie

22. Name and Address of Facility: R. T. Foard Funeral Home, P. A. 111 S. Queen St., Rising Sun, MD 21911

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Dementia of Alzheimers Type — years

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [X] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Sanders MD

29c. License number: D23322

29d. Date signed (Month, Day, Year): 3.21.01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): J.S. SANDERS MD 118 North St Suite 3B, Elkton MD 21921

State Registrar

31. Date filed (Month, Day, Year): MAR 23 2001

32. Registrar's Signature: B. Sparks

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

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DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 10421

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Albert Busta

2. Date of Death: Month March Day 23 Year 2001

3. Time of Death: 10:55 am

4a. Facility Name (If not institution, give street and number): Laurelwood Nursing Center

4b. City, Town, or Location of Death: Elkton

4c. County of Death: Cecil

Funeral Director

5. Social Security Number: 218-20-6637

6. Sex: 1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday): 74 Yrs.

If Under 1 Year: Months ____ Days ____

If Under 24 Hrs.: Hours ____ Min. ____

8. Date of Birth (Month, Day, Year): Nov. 23, 1926

9. Birthplace (State or Foreign Country): Maryland

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: Maryland

10b. County: Harford

10c. City, Town or Location: Havre de Grace

10d. Inside City Limits: 1 ☒ Yes 2 ☐ No

10e. Street and Number: 255 Wilson Street

10f. Zip Code: 21078

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 ☒ Yes 2 ☐ No If Yes, Give Year or Dates: 1945-46

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): Eight Years

College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Shipping Clerk

16b. Kind of Business/Industry: Continental Can Company Cambridge, Maryland

17. Father's Name (First, Middle, Last): John Busta

18. Mother's Name (First, Middle, Maiden Surname): Lillian Spean

19a. Informant's Name/Relationship (Type, Print): Karen Busta (daughter)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 255 Wilson Street, Havre de Grace, Maryland 21078

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Unity-Washington Church Cemetery

Date: 3/27/01

20c. Location - City or Town, State: Hurlock, Maryland

21. Signature of Funeral Service Licensee: ▶ Thomas M. Patterson, Sr.

22. Name and Address of Facility: Lee A. Patterson & Son Funeral Home, P.A. Perryville, Maryland 21903-0766

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Senile Dementia of Alzheimer's Type — 1 year

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. ____

Due to (or as a consequence of):

c. ____

Due to (or as a consequence of):

d. ____

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other: 4 ☑ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1 ☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Monte Makous, MD

29c. License number: D-44783

29d. Date signed (Month, Day, Year): March 23, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): MONTE MAKOUS, MD 100 LAUREL Drive, ELKTON, MD 21921

State Registrar

31. Date filed (Month, Day, Year): MAR 26 2001

32. Registrar's Signature: ▶ Geneva G. Sparks

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 16 Rev 6/95

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

1- For State Registrar

Reg. No. 2001 10422

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Margaret S. Brown
2. Date of Death (Month, Day, Year): March 24 2001
3. Time of Death: 2235 M
4a. Facility Name (If not institution, give street and number): Union Hospital of Cecil County
4b. City, Town, or Location of Death: Elkton
4c. County of Death: Cecil

Funeral Director

5. Social Security Number: 218-32-8850
6. Sex: 1☐M 2☒F
7. Age (In yrs. last birthday): 64 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): May 16, 1936
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Cecil
10c. City, Town or Location: Elkton
10d. Inside City Limits: 1☐Yes 2☒No
10e. Street and Number: 1 Price Drive
10f. Zip Code: 21921
10g. Citizen of What Country?: USA

11. Marital Status: 1☐Never Married 2☐Married 3☐Widowed 4☒Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐Yes 2☒No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 / College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Nurse
18b. Kind of Business/Industry: Healthcare

17. Father's Name (First, Middle, Last): Taylor P. Brown
18. Mother's Name (First, Middle, Maiden Surname): Emma M. Willis

19a. Informant's Name/Relationship (Type, Print): Marie Janney/Sister
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1848 Tome Hwy., Rising Sun, MD 21911

20a. Method of Disposition: 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Friends Cemetery
Date: 3-27-2001
20c. Location - City or Town, State: Rising Sun, Maryland

21. Signature of Funeral Service Licensee: Richard L. Goodie
22. Name and Address of Facility: R. T. Foard Funeral Home, P. A. 111 S. Queen St., Rising Sun, MD 21911

Physician /Medical Examiner

23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
Approximate Interval Between Onset and Death

Immediate Cause (Final disease of condition resulting in death): a. pneumonia — 10 days
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. Due to (or as a consequence of):

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐Yes 2☒No 9☐Unknown
23c. If yes, outcome of pregnancy: 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown
23d. Date of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☒Unknown

24a. Was an autopsy performed? 1☐Yes 2☒No
24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☒No

25. Was case referred to medical examiner? 1☐Yes 2☒No

28. Place of Death (Check only one): Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☐Residence 8☐Other (Specify)

27. Manner of Death: 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐Yes 2☐No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Joshua M. Caron MD
29c. License number: D0047471
29d. Date signed (Month, Day, Year): March 25, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Suite 101 111 W. High St. Elkton Maryland 21921

State Registrar

31. Date filed (Month, Day, Year): MAR 27 2001
32. Registrar's Signature: ▶ B. Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Medical Certification; To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 10423

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death (Month, Day, Year)	3. Time of Death
Harriette Marguerite Beavers	March 13, 2001	05:48 AM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
45186 Clarks Landing Road	Hollywood	St. Mary's

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
212-18-3553	1☐M 2☒F	82 Yrs.			November 18, 1918	Maryland

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	St. Mary's	Hollywood	1☐Yes 2☒No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
45186 Clarks Landing Road	20636	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐Never Married 2☐Married 3☒Widowed 4☐Divorced	1☐Yes 2☒No If Yes, Give Year or Dates:	1☐Yes 2☒No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12		Homemaker	Own Home

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
George Emory Simmons	Hattie D. Botler

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Patti Johnson / Daughter	45186 Clarks Landing Road Hollywood, MD 20636

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	Charles Memorial Gardens	March 14, 2001	Leonardtown, Maryland

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
Michael K Gardiner	Mattingley-Gardiner Funeral Home, P.A. PO Box 270 Leonardtown MD 20650

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Cardio-respiratory arrest	minutes
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of): b. acute cerebrovascular accident	days
	Due to (or as a consequence of): c.	
	Due to (or as a consequence of): d.	

IF FEMALE: 23b. Was decedent pregnent in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery
1☐Yes 2☒No 9☐Unknown	1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnent at time of death 5☐Other (specify) _____ 9☐Unknown	Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Alzheimer's dementia

23e. Did tobacco use contribute to the cause of death?	24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐Yes 2☒No 3☐Probably 4☐Unknown	1☐Yes 2☒No	1☐Yes 2☐No

Medical Certification: To Be Completed by Physician/Medical Examiner

25. Was case referred to medical examiner?	28. Place of Death (Check only one)	
1☐Yes 2☒No	Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA	Other: 4☐Nursing Home 5☒Residence 6☐Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined		M	1☐Yes 2☐No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
MD	D42597	3-14-01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Jeffrey Brown, MD Leonardtown, Maryland 20650

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
MAR 16 2001	D. Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 10424

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: William McDonald Bryant, Jr.

2. Date of Death Month / Day / Year: March 27, 2001

3. Time of Death: 5:50 PM

4a. Facility Name *(If not institution, give street and number)*: St. Mary's Nursing Center

4b. City, Town, or Location of Death: Leonardtown

4c. County of Death: St. Mary's

Funeral Director

5. Social Security Number: 220-16-4930

6. Sex: 1 [X] M 2 [ ] F

7. Age *(In yrs. last birthday)*: 87 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: March 22, 1914

9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: St. Mary's

10c. City, Town or Location: Avenue

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 20910 Mattingly Road

10f. Zip Code: 20609

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 6th | College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Waterman

16b. Kind of Business/Industry: Seafood

17. Father's Name *(First, Middle, Last)*: William M. Bryant, Sr.

18. Mother's Name *(First, Middle, Maiden Surname)*: Julia Ann Russell

19a. Informant's Name/Relationship *(Type, Print)*: Louise Thompson Bryant/ Sister in law

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: P.O. Box 42, Coltons Point, Maryland 20626

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Sacred Heart Cemetery

Date: 3/30/01

20c. Location - City or Town, State: Bushwood, Maryland

21. Signature of Funeral Service Licensee: Michael Kevin Gardner

22. Name and Address of Facility: Mattingley-Gardiner Funeral Home, P.A. Leonardtown, Maryland 20650

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Cerebrovascular Accident — Minutes

Due to (or as a consequence of):

b. Hypertension — Years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c. Muscular Dystrophy — Years

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death *(Check only one)*: Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | Other: 4 [X] Nursing Home 5 [ ] Residence 6 [ ] Other *(Specify)*

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier:

29c. License number: D42597

29d. Date signed *(Month, Day, Year)*: March 30, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Dr. Jeffrey Brown, MD Leonardtown, Maryland 20650

State Registrar

31. Date filed *(Month, Day, Year)*: MAR 30 2001

32. Registrar's Signature: Donna S. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 10425

Physician /Medical Examiner

Funeral Director

To Be Completed by Funeral Director

1. Decedent's Name (First, Middle, Last)			2. Date of Death Month Day Year	3. Time of Death
Mary	Catherine	Baxter	March 10, 2001	11:00 AM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
28305 Thompson Corner Road	Mechanicsville	St. Mary's

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
578-22-7158	1☐M 2☒F	77 Yrs.			Feb. 18, 1924	Washington, DC

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	St. Mary's	Mechanicsville	1☐Yes 2☒No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
28305 Thompson Corner Road	20659	U S A

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐Never Married 2☐Married 3☒Widowed 4☐Divorced	1☐Yes 2☒No If Yes, Give Yeer or Dates:	1☐Yes 2☒No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12th Grade		Homemaker	Own Home

17. Father's Name (First, Middle, Last)		18. Mother's Name (First, Middle, Meiden Sumame)	
George	Quigley	Winifred	O'Rourke

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 20659
Patricia Hayes (Daughter)	28305 Thompson Corner Road, Mechanicsville, Maryland

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, cremetory or other placa)	Date	20c. Location - City or Town, State
1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	St. Mary's Church	3/13/2001	Bryantown, Maryland

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ [signature]	Brinsfield-Echols Funeral Home, P.A. P.O. Box 128, Charlotte Hall, Maryland 20622

Physician /Medical Examiner

Medical Certification; To Be Completed by Physician/Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Cardiopulmonary Arrest

Due to (or as a consequence of):
b. General Debility

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequenca of):
c. Anorexia

Due to (or as a consequence of):
d.

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery
1☐Yes 2☒No 9☐Unknown	1☐Live birth 2☐Fetal death 3☐Ectopic pregnency 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown	Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Neurogenic bladder
bilateral leg weakness due to back injury
Depression

23e. Did tobacco use contribute to the causa of death? 1☐Yes 2☐No 3☐Probably 4☒Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐Yes 2☒No	1☐Yes 2☐No

25. Was case referred to medical examiner?	28. Place of Death (Check only one)
1☐Yes 2☒No	Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☒Residence 8☐Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined		M	1☐Yes 2☐No	

28e. Placa of Injury - At home, farm, street, factory, offica building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and placa, and due to the cause(s) and manner as steted. 2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) end manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ [signature]	D51738	03-12-01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Kae T. Aung, MD Hollywood, Maryland 20636

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
MAR 19 2001	[signature]

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than 'natural', or Items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

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To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 10426

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Minnie Marie Frieder Wilhoit Brown

2. Date of Death (Month, Day, Year): March 11, 2001

3. Time of Death: 2:20 AM

4a. Facility Name (If not institution, give street and number): 45335 Clarks Mill Road

4b. City, Town, or Location of Death: Hollywood

4c. County of Death: St. Mary's

Funeral Director

5. Social Security Number: 577-01-1759

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 90 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): August 30, 1910

9. Birthplace (State or Foreign Country): Washington, DC

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: Maryland

10b. County: St. Mary's

10c. City, Town or Location: Hollywood

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 45335 Clarks Mill Road

10f. Zip Code: 20636

10g. Citizen of What Country? USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify: X

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 12th

College (1-4or 5+):

16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Manager

18b. Kind of Business/Industry: Telephone Company

17. Father's Name (First, Middle, Last): Alexander Alfred Frieder

18. Mother's Name (First, Middle, Maiden Surname): Ann Elizabeth King

19a. Informant's Name/Relationship (Type, Print): John Alexander Wilhoit (Son)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 45335 Clarks Mill Road, Hollywood, Maryland 20636

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Gate of Heaven Cemetery

Date: March 14,2001

20c. Location - City or Town, State: Silver Spring, Maryland

21. Signature of Funeral Service Licensee: Michael L Gardiner

22. Name and Address of Facility: Mattingley-Gardiner Funeral Home, P.A. P.O. Box 270, Leonardtown, Maryland 20650

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Failure to Thrive — 2 months

Due to (or as a consequence of):

b. CAD — long time

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

If FEMALE:

23b. Was decedent pregnant in the past 12 months? 1☐ Yes 2☒ No 9☐ Unknown

23c. If yes, outcome of pregnancy 1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) 9☐ Unknown

23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24e. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

Medical Certification; To Be Completed by Physician/Medical Examiner

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one)

Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA

Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: A Shah

29c. License number: D 47066

29d. Date signed (Month, Day, Year): 3.12.01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): A.D. Shah, MD Leonardtown, Maryland 20650

State Registrar

31. Date filed (Month, Day, Year): MAR 13 2001

32. Registrar's Signature

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than 'natural', or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 17 Rev 1/2001

ORIGINAL

01-1233-037
CJ
John L. Butler

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg.No. 2001 10427

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month	Day	Year	3. Time of Death
John Lathana Butler Jr.	March	05	2001	02:20 A.M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Liberty Street at Pegg Road	Lexington Park	St. Mary's

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months	Days	If Under 24 Hrs.: Hours	Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
220-78-0261	1 X M 2 F	27 Yrs.					January 18, 1974	Maryland

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	St. Mary's	Lexington Park	1 Yes 2 X No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
46400 Chapman Drive	20653	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1 X Never Married 2 Married 3 Widowed 4 Divorced	1 Yes 2 X No If Yes, Give Year or Dates:	1 Yes 2 X No Specify:	Specify: Black

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
11		Laborer	Construction

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
John Henry Butler	Doris Marie Jordan

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Doris Marie Chew/Mother	46400 Chapman Drive Lexington Park MD 20653

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)	Charles Memorial Gardens	March 10, 2001	Leonardtown, MD

21. Signature of Funeral Service Licensee: Michael Kevin Gardiner Jr.

22. Name and Address of Facility: Mattingley-Gardiner Funeral Home, P.A. PO Box 270 Leonardtown, MD 20650

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Gunshot wound of Back of Neck	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of):	
	c. Due to (or as a consequence of):	
	d. Due to (or as a consequence of):	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery
1 Yes 2 No 9 Unknown	1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify) 9 Unknown	Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?	24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1 Yes 2 X No 3 Probably 4 Unknown	1 X Yes 2 No	1 X Yes 2 No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1 X Yes 2 No	Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA	Other: 4 Nursing Home 5 Residence 8 X Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1 Natural 2 Accident 3 Suicide 4 X Homicide 5 Pending investigation 6 Could not be determined	3/5/01	0217 M	1 Yes 2 X No	Subject Shot

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)
STREET	Pegg Rd, 20653

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1 **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 X **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
	O.C.M.E.	March 5, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): J. Theron Lockett MD 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
MAR 0 8 2001	

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 10428

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Alice Lucille Buchanan

2. Date of Death — Month: MARCH Day: 2 Year: 2001

3. Time of Death: 07:58 AM

4a. Facility Name *(If not institution, give street and number)*: St. Mary's Hospital

4b. City, Town, or Location of Death: Leonardtown

4c. County of Death: St. Mary's

Funeral Director

5. Social Security Number: 212-78-3466

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 90 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: July 16 1910

9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: St. Mary's

10c. City, Town or Location: Leonardtown

10d. Inside City Limits: 1☐ Yes 2☐ No

10e. Street and Number: 42593 St. Andrews Church Road

10f. Zip Code: 20650

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* Black

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 2nd — College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Housekeeper

16b. Kind of Business/Industry: Private Homes

17. Father's Name *(First, Middle, Last)*: John Price

18. Mother's Name *(First, Middle, Maiden Surname)*: Annie Marshall

19a. Informant's Name/Relationship *(Type, Print)*: Oscar G. Buchanan

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 42593 St. Andrews Church Rd Leonardtown MD 20650

20a. Method of Disposition: 1☐ Burial 2☐ Cremation 3☐ Removal from State 4☒ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Charles Memorial Gardens — Date: 3/6/01

20c. Location - City or Town, State: Leonardtown MD

21. Signature of Funeral Service Licensee: Michael K Gardiner

22. Name and Address of Facility: Mattingley-Gardiner Funeral Home, P.A. PO Box 270 Leonardtown MD 20650

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. A Neurodegenerative Cardiovascular Disease — YRS

Due to (or as a consequence of):
b.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☒ Yes 2☐ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☒ DOA — Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day, Year)*

28b. Time of Injury

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☐ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☒ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: M Boyd Tamm

29c. License number: D14285

29d. Data signed *(Month, Day, Year)*: 3-2-01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): WILLIAM D.BOYD II M.D. P.O. BOX 1753 LEONARDTOWN.MD. 20650

State Registrar

31. Data filed *(Month, Day, Year)*: MAR 05 2001

32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

ALICE BUCHANAN

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

Amend Item#14 perFHG795 5/2/01 EW

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 10429

Physician /Medical Examiner

1. Decedent's Neme (First, Middle, Last)	2. Date of Death Month Dey Year	3. Time of Death
CLYDE H. BROWN, SR.	MAR. 19 2001	10:20PM

4a. Facility Neme (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Howard County General Hospital	Columbia	Howard

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year Months / Deys	If Under 24 Hrs. Hours / Min.	8. Dete of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
218-36-1409	1☒M 2☐F	92 Yrs.			June 16, 1908	Maryland

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	Howard	Dayton	1☐Yes 2☒No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
13825 Howard Road	21036	USA

11. Merital Stetus	12. Wes Decedent Ever in U.S. Armed Forces?	13. Wes Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Bleck, White, etc.
1☐Never Merried 2☐Merried 3☒Widowed 4☐Divorced	1☐Yes 2☒No If Yes, Give Yeer or Dates:	1☐Yes ☒No Specify:	Specify: ~~USA~~ White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedant's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elemantary/Secondary (0-12)	College (1-4or 5+)		
12		Farmer	Agriculture

17. Father's Neme (First, Middle, Last)	18. Mother's Neme (First, Middle, Maiden Surname)
John H. Brown	Annie P. Leishear

19e. Informent's Neme/Reletionship (Type, Print)	19b. Melling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code)
Mrs. Dorothy Titherington (Daughter)	13825 Howard Road Dayton, MD 21036

20a. Method of Disposition	20b. Piece of Disposition (Neme of cemetary, crametory or other piece)	Dete	20c. Location - City or Town, Stete
1☒Burial 2☐Cremation 3☐Removal from Stete 4☐Donation 5☐Other (Specify)	St. Mark's Church Cemetery	3/23/01	Highland, MD

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ Brian L. Haight	HAIGHT FUNERAL HOME & CHAPEL, PA (Box 195) Sykesville, MD 21784 (410)-795-1400

Physician /Medical Examiner

23a. Part1. Enter tha diseese, or complicetions that caused the deeth. Do not enter the mode of dying, such es cardiec or respiretory errest, shock, or heert feilure. List only one ceuse on eech line.

		Approximete Interval Between Onset and Death
Immediete Cause (Finel disease or condition resulting in deeth)	a. Cerebrovascular Accident	30 hours.
	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediete cause. Enter Underlying Cause (Disease or injury thet initiated events resulting in death) Last	b.	
	Due to (or as e consequence of):	
	c.	
	Due to (or es a consequence of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying causa given in Pert I.

23b. **Did tobacco use contribute to the cause of death?** 1☐Yes 2☐No 3☐Probably 4☒Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings aveilable prior to completion of cause of death?
1☐Yes 2☒No	1☐Yes 2☐No

25. Wes case referred to medical examiner?	26. Place of Death (Check only one)	
1☐Yes 2☒No	Hospital: 1☒Inpatiant 2☐ER/Outpatient 3☐DOA	Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Menner of Deeth	28e. Dete of Injury (Month, Dey Year)	28b. Time of Injury M	28c. Injury at Work?	28d. Describe how injury occurred
1☒Netural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined			1☐Yes 2☐No	
	28e. Piece of Injury - At home, farm, street, fectory, office building, etc. (Specify)			28f. Location (Street end Number or Rural Route Number, City or Town, Steta)

29e. Certifier (Check only one)
1☒**Certifying Phyaician:** To the best of my knowledge, daath occurred at the tima, data and placa, and dua to tha cause(s) end mennar as stated.
2☐**Medical Examiner:** On tha basis of axamination and/or investigation, in my opinion, daeth occurred at the time, date and placa, and due to tha cause(s) end mannar steted.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ Abeda Ali Khan M.D.	D43323	MAR. 20, 2001

30. Name and address of person who completed causa of daeth (Item 23a) (Type, Print) ABEDA ALI KHAN. 10794 Hickory Ridge Road Columbia, MD 21044

State Registrar

31. Date filed (Month, Day, Year)	32. Registrer's Signeture
MAR 22 2001	▶ Geneva G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

WJL 10

RKD

01-1611-019

ROBERT BELL

1- For State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 10430

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
Robert Bell	MARCH 22, 2001	11:30A. M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
503 BURTON STREET	CAMBRIDGE	DORCHESTER

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
195-10-6453	1☒M 2☐F	82 Yrs.			June 13 1918	Pennsylvania

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	Dorchester	Cambridge	1☒Yes 2☐No

10e. Street and Number	10f. Zip Code	10g. Citizan of Whet Country?
503 Burton Street	21613	U.S.A.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Rece - American Indien, Black, White, etc.
1☐Nevar Married 2☐Married 3☒Widowed 4☐Divorced	1☒Yes 2☐No If Yes, Give Year or Dates: WWII	1☐Yes 2☒No Specify:	Specify: white

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	18b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
11		self employed	awning and canvas

17. Father's Name (First, Middle, Last)	18. Mother's Neme (First, Middle, Meiden Surname)
George Bell	Martha Kennedy

19e. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Michael W. Bell son	503 Burton St., Cambridge, MD 21613

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☐Burial 2☒Cremetion 3☐Removal from State 4☐Donation 5☐Other (Specify)	Salisbury Crematory	3-27	Salisbury, Maryland

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ [signature]	Thomas Funeral Home PA 700 Locust St., Cambridge, MD 21613

Physician /Medical Examiner

Medical Certification; To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onsat and Death
Immediate Cause (Finat disease or condition resulting in death)	Hypertensive Arteriosclerotic Cardiovascular Disease	
Sequentially list conditions, if any, leading to immediete cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to (or as a consequence of):	
	b. Due to (or as a consequence of):	
	c. Due to (or as a consequence of):	
	d.	

IF FEMALE: 23b. Wes decedent pregnant in the past 12 months? 1☐Yes 2☐No 9☐Unknown	23c. If yes, outcoma of pregnancy 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown	23d. Dete of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobecco use contribute to the cause of death?	24e. Was en autopsy performed?	24b. Were eutopsy findings available prior to completion of cause ol daath?
1☐Yes 2☐No 3☐Probebly 4☒Unknown	1☐Yes 2☒No	1☐Yas 2☐No

25. Was case referred to medical examiner?	28. Place of Death (Check only one)	
XX Yas 2☐No	Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA	Other: 4☐Nursing Home 5☐Residence 6☒Other (Specify) SCENE

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work?	28d. Describe how injury occurrad
1XX Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined			1☐Yas 2☐No	
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Streat and Number or Rural Route Numbar, City or Town, State)

29a. Certifier (Check only one) 1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and dua to the cause(s) end mannar es stated.
2☒ **Medical Examiner:** On the basis of axamination and/or investigation, in my opinion, death occurred et the time, date end place, end due to tha cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Dey, Year)
▶ Theodore M. King MD	O.C.M.E.	MARCH 23, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Theodore King M.D. 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
MAR 2 6 2001	[signature]

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or Items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

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To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Amend #'s 7.& 8.Per F.H & Fam.PGC 3-26-01 cr **Certificate of Death** Reg.No. 2001 10431

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Adelle Blackwell
2. Date of Death Month Day Year: March 11, 2001
3. Time of Death: 2:35am
4a. Facility Name *(If not institution, give street and number)*: Southern Maryland Hospital
4b. City, Town, or Location of Death: Clinton
4c. County of Death: Prince George's

Funeral Director

5. Social Security Number: 579-46-4012
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: ~~83~~ 93 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: Oct. 16, ~~1917~~ 1907
9. Birthplace *(State or Foreign Country)*: Lynchburgh, Va.

Usual Residence of Decedant

10a. State: Maryland
10b. County: Prince George's
10c. City, Town or Location: Largo
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 500 N. Harry S. Truman DR.
10f. Zip Code: 20774
10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* Black

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 8 / College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Homemaker
16b. Kind of Business/Industry: Private

17. Father's Name *(First, Middle, Last)*: James Andrews
18. Mother's Name *(First, Middle, Maiden Surname)*: Pauline Marshall

19a. Informant's Name/Relationship *(Type, Print)*: Frank J. Blackwell/ Son
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 814 Carrington Ave. Seat Pleasant, Md. 20743

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetary, crematory or other place)*: Resurrection Cemetery
Date: 3/17/01
20c. Location - City or Town, State: Clinton, Md.

21. Signature of Funeral Service Licensee: Luther Savoy 03/11/01
22. Name and Address of Facility: Alexander S. Pope Funeral Homes 5538 Marlboro Pike/Forestville, Md. 20747

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Septic Shock
Due to (or as a consequence of):
b. Fluid Overload
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c. Anemia
Due to (or as a consequence of):
d. Asystole

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
Sacral Decubitus Ulcer, Thrombocytopenia, Dementia

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death *(Check only one)*: Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: MD
29c. License number: D0053219
29d. Data signed *(Month, Day, Year)*: 3.11.01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Zafar Ansari, M.D. 7 E. Post Office Rd. Waldorf, Md. 20602

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

Blackwell, Adelle # 1012515

(3)

State Registrar

31. Date filed *(Month, Day, Year)*: MAR 19 2001
32. Registrar's Signature: Donna B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 10432

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: ADA Lee Bullock
2. Date of Death Month / Day / Year: March 14 2001
3. Time of Death: 9:30AM
4a. Facility Name *(If not institution, give street and number)*: STELLA Maris
4b. City, Town, or Location of Death: Timonium
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 215-05-9466
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 91 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: July 7, 1909
9. Birthplace *(State or Foreign Country)*: NC

Usual Residence of Decedent

10a. State: MD
10b. County: Baltimore
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 1733 CLIFFVIEW Avenue
10f. Zip Code: 21213
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No — If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* Black

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 8 — College (1-4or 5+): —
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Seamtress
16b. Kind of Business/Industry: Private IND.

17. Father's Name *(First, Middle, Last)*: Jim Shepard
18. Mother's Name *(First, Middle, Maiden Surname)*: Supina Cmaiden UNKNOWN)

19a. Informant's Name/Relationship *(Type, Print)*: (Daughter) GloriaCarter-Etheridge
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 2725 Guildford Ave. Baltimore MD 21218

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Maryland National Cem. — Date: 3/20/01
20c. Location - City or Town, State: Laurel, MD

21. Signature of Funeral Service Licensee: ▶ Leander M. Coles
22. Name and Address of Facility: TRI-STATE F/S 108 W. North Ave. Baltimore MD

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. COLON CANCER
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 6☒ Other *(Specify)* HOSPICE

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29e. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ MD
29c. License number: D43725
29d. Date signed *(Month, Day, Year)*: 3/16/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): DR. TARIQ MAHMOOD 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093

State Registrar

31. Date filed *(Month, Day, Year)*: MAR 2 0 2001
32. Registrar's Signature: ▶ G. Sparks

DHMH 16 Rev 6/95

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Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

MARCH 14, 2001 9:30 a.m.

ADA BULLOCK

3

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Amend #'s 20a.20b.& 20c.Per FH PGC 3-21-01 cr **Certificate of Death**

Reg. No. 2001 10433

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month	Day	Year	3. Time of Death
Toussaint St. Augustine Bent	March	11	2001	4:00 AM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
SHADY GROVE ADVENTIST HOSPITAL	ROCKVILLE	MONTGOMERY

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months	Days	If Under 24 Hrs.: Hours	Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
577-78-4331	1☒ M 2☐ F	52 Yrs.					July 2,1948	West Jamaica,Indies

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Montgomery	Silver Spring	1☒ Yes 2☐ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
1532 Ingram Terrace	20906	United States

11. Marital Status	12. Was Decedent Ever In U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced	1☐ Yes 2☒ No If Yes, Give Year or Dates:	1☐ Yes 2☒ No Specify:	Specify: Black

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementery/Secondary (0-12)	College (1-4or 5+)		
12th grade		Service Station Attendant	Gas Station

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Meiden Surneme)
Headley Bent	Ernie Lucine Pencle

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Marie Hyacinth McFarlane (Sister)	1532 Ingram Terrace, Silver Spring,Maryland 20906

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other piece)	Date	20c. Location - City or Town, State
1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)	Chesapeake Crematory ~~Gate of Heaven Cemetery~~	March 17,2001	Beltsville, ~~Silver Spring~~,Maryland

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
Kenneth Mann	R. N. Horton Company Morticians, Inc. 600 Kennedy Street,N.W.;Washington,D.C. 20011

Physician /Medical Examiner

23a. Part1. Enter the diseese, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one ceuse on eech line.

		Approximete Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. CHRONIC Obstructive pulmonary disease	years
	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b.	
	Due to (or as a consequence of):	
	c.	
	Due to (or as a consequence of):	
	d.	

Part ff. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Part I.

Bilateral pleural thickening Chronic pulmonary infiltrate

23b. Did tobacco use contribute to the cause of death? 1☒ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of ceuse of death?
1☐ Yes 2☒ No	1☐ Yes 2☐ No

25. Was case referred to medical exeminer?	26. Place of Death (Check only one)	
1☐ Yes 2☒ No	Hospital: 1☒ Inpatient 2☐ ER/Outpetient 3☐ DOA	Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death	28a. Dete of Injury (Month, Dey Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined		M	1☐ Yes 2☐ No	
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and piece, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or Investigation, in my opinion, deeth occurred et the time, date and piece, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
Alan Shnaider MD	29453	March 11, 2001

30. Name and address of person who completed ceuse of death (Item 23a) (Type, Print)

ALAN S. CHANADES, 15215 SHADY GROVE RD, ROCKVILLE MD 20850

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
MAR 14 2001	Bernard P. Spencer M.D.

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print In Black Indellble Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 10434

Amend # 28c. Per Phys. P.G.C. 3-22-01 cR

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Michael Bradshaw
2. Date of Death (Month, Day, Year): March 20 2001
3. Time of Death: 10:56 Am
4a. Facility Name (If not Institution, give street and number): Fort Washington Hospital
4b. City, Town, or Location of Death: Fort Wash.
4c. County of Death: P.G.

Funeral Director

5. Social Security Number: 577-92-6188
6. Sex: 1 ☒ M 2 ☐ F
7. Age (In yrs. last birthday): 41 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Sept. 29, 1959
9. Birthplace (State or Foreign Country): Washington, D.C.

Usual Residence of Decedent

10a. State: md
10b. County: P.G.
10c. City, Town or Location: Oxon Hill
10d. Inside City Limits: 1 ☒ Yes 2 ☐ No
10a. Street and Number: 1007 Marcy Ave #203
10f. Zip Code: 20745
10g. Citizen of What Country? U.S.A.

11. Marital Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: BLACK

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12½ College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): COOK
16b. Kind of Business/Industry: Levi's

17. Father's Name (First, Middle, Last): Clifford Roy Bradshaw
18. Mother's Name (First, Middle, Maiden Surname): Anita Anderson

19a. Informant's Name/Relationship (Type, Print): Deborah Bradshaw / w.fe
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 520 Wilson Bridge Dr #B2 Oxon Hill, md 20745

20a. Method of Disposition: 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Riverdale Crematory
Date: 3-27-01
20c. Location - City or Town, State: Riverdale, md.

21. Signature of Funeral Service Licensee: Janet C. Anderson
22. Name and Address of Facility: Dunn & Sons Funeral Service 5635 Eads St, N.E.

cR

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Cardiopulmonary arrest
Due to (or as a consequence of):
b. Seizure disorder
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c. liver failure
Due to (or as a consequence of):
d. alcohol abuse

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No
26. Place of Death (Check only one): Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☒ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: Abdulhasin Adham
29c. License number: 015557
29d. Date signed (Month, Day, Year): 3/22/01 10 AM

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Abdulhasin Adham 4467 Old Branch Ave. Ste. 201 Temple Hill, MD 20748

State Registrar

31. Date filed (Month, Day, Year): MAR 22 2001
32. Registrar's Signature: Barbara G. Sparks

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

(3)

DHMH 16 Rev 6/95

ORIGINAL

01-1550-033
LISA BOGGS
JVW

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar AMEND ITEMS 23a,27,28a-f per ME G794 040601 SS

Certificate of Death

Reg. No. 2001 10435

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
Lisa Boggs	MARCH 19, 2001	11:25 P M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
PRINCE GEORGE'S HOSPITAL CENTER	CHEVERLY	PRINCE GEORGE'S

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
578-02-9458	1☐ M 2☒ F	34 Yrs.			05-30-1966	Washington, DC

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	Prince Georges	Suitland	1☒ Yes 2☐ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
4311 Offert Dr	20706	U.S.A.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced	1☐ Yes 2☒ No If Yes, Give Year or Dates:	1☐ Yes 2☒ No Specify:	Specify: Black

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12th		Correspondance Technician	Government

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Willard Scott	Adrian Wilkerson

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Carlton Boggs/Husband	4311 Offert Dr Suitland, MD 20706

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)	Cedar Hill Cemetery	3-26-2001	Suitland, MD

21. Signature of Funeral Service Licensee ▶ [signature]

22. Name and Address of Facility J.B. Jenkins Funeral Home
7474 Landover Rd Landover, MD 20785

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23e or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	e. ETHANOL, BENZODIAZEPINE, AND NARCOTIC INTOXICATION	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of):	
	b. Due to (or as a consequence of):	
	c. Due to (or as a consequence of):	
	d.	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month Day Year
1☐ Yes 2☐ No 9☒ Unknown	1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) _____ 9☐ Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☒ Yes 2☐ No	1☒ Yes 2☐ No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☒ Yes 2☐ No	Hospital: 1☐ Inpatient 2☒ ER/Outpatient 3☐ DOA	Other: 4☐ Nursing Home 5☐ Residence 8☐ Other (Specify)

Medical Certification; To Be Completed by Physician/Medical Examiner

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☐ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☒ Could not be determined	found: 3-19-01	found: 11:10 P M	1☐ Yes 2☒ No	unknown

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)
found: apartment	5901 East Capitol St., SE Washington, DC

29a. Certifier (Check only one)
1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☒ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of Certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ [signature] M.D.	O.C.M.E.	MARCH 20, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
MARY G. RIPPLE, M.D. 111 Penn Street, Baltimore, Maryland 21201

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
MAR 27 2001	▶ [signature]

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 10436

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Patricia Joyce BOOTH

2. Date of Death: Month: March; Day: 25; Year: 01

3. Time of Death: 4:05 PM

4a. Facility Name (If not institution, give street and number): 609 Fair Meadows Blvd.

4b. City, Town, or Location of Death: Hagerstown

4c. County of Death: Washington

Funeral Director

5. Social Security Number: 214-32-4782

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 65 Yrs.

If Under 1 Year: Months: ; Days:

If Under 24 Hrs.: Hours: ; Min.:

8. Date of Birth (Month, Day, Year): April 27 1935

9. Birthplace (State or Foreign Country): N. Carolina

Usual Residence of Decedent

10a. State: Maryland

10b. County: Washington

10c. City, Town or Location: Hagerstown

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 1202 Greendale

10f. Zip Code: 21742

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 12

College (1-4or 5+): 2

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Computer Specialist

16b. Kind of Business/Industry: I.R.S.

17. Father's Name (First, Middle, Last): Wilbert Earl Dennis

18. Mother's Name (First, Middle, Maiden Surname): Ava Lola Hicks

19a. Informant's Name/Relationship (Type, Print): Linda Schindel - Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 609 Fair Meadows Blvd. Hagerstown, Md. 21740

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Rest Haven Cemetery

Date: 3/28/01

20c. Location - City or Town, State: Hagerstown, Maryland

21. Signature of Funeral Service Licensee: Fred L Wachtel

22. Name and Address of Facility: Minnich Funeral Home 415 E. Wilson Blvd. Hagerstown, Maryland 21740

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Ovarian Cancer — 2 years

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death (Check only one)

Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA

Other: 4☐ Nursing Home 5☐ Residence 6☑ Other (Specify) daughter's house

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Michael J. McCormack MD

29c. License number: 041667

29d. Date signed (Month, Day, Year): 3-27-01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Michael J. McCormack 11110 Medical Campus Hagerstown MD 21742

State Registrar

31. Date filed (Month, Day, Year): MAR 27 2001

32. Registrar's Signature

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 28a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 10437

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Richard Leon BAKER
2. Date of Death (Month, Day, Year): March 19, 2001
3. Time of Death: 1:45 P.M.
4a. Facility Name (If not institution, give street and number): 10728 Bower Avenue
4b. City, Town, or Location of Death: Hagerstown
4c. County of Death: Washington

Funeral Director

5. Social Security Number: 217-32-6943
6. Sex: 1☒ M 2☐ F
7. Age (In yrs. last birthday): 63 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): April 28, 1937
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Washington
10c. City, Town or Location: Hagerstown
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 10728 Bower Avenue
10f. Zip Code: 21740
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☒ Yes 2☐ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: white

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+): 0
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): mechanic
16b. Kind of Business/Industry: refrigeration

17. Father's Name (First, Middle, Last): Ernest R. Baker
18. Mother's Name (First, Middle, Maiden Surname): Ethel G. Reeder

19a. Informant's Name/Relationship (Type, Print): Richard L. Baker, II - son
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2350 Ridge Tree Court, Ellicott City, Md. 21042

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Rest Haven Cemetery | Date: 3-22-01
20c. Location - City or Town, State: Hagerstown, Maryland

21. Signature of Funeral Service Licensee: Scott M Minnich
22. Name and Address of Facility: MINNICH FUNERAL HOME 415 E.Wilson Blvd.,Hagerstown, Md. 21740

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death):
a. METASTATIC RENAL CELL CARCINOMA — 3 MONTHS
Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
CORONARY ARTERY DISEASE
VENTRICULAR TACHYCARDIA

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☑ Residence 6☐ Other (Specify)
27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: Pamela Fox Bradford MD
29c. License number: D38892
29d. Date signed (Month, Day, Year): 3/20/01
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): PAMELA FOX BRADFORD MD 11110 MEDICAL CAMPUS RD. SUITE 130 HAGERSTOWN, MD 21742

State Registrar

31. Date filed (Month, Day, Year): MAR 22 2001
32. Registrar's Signature:

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important:** If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 10438

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Frances nmn BROUSSEAU

2. Date of Death — Month: March Day: 19 Year: 2001

3. Time of Death: 1408

4a. Facility Name (If not institution, give street and number): Washington County Hospital

4b. City, Town, or Location of Death: Hagerstown

4c. County of Death: Washington

Funeral Director

5. Social Security Number: 080-12-9028

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 79 Yrs.

If Under 1 Year — Months: Days:

If Under 24 Hrs. — Hours: Min.:

8. Date of Birth (Month, Day, Year): Oct. 12 1921

9. Birthplace (State or Foreign Country): New York

Usual Residence of Decedent

10a. State: Maryland

10b. County: Washington

10c. City, Town or Location: Williamsport

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 10913 Stuart Drive

10f. Zip Code: 21795

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed) — Elementary/Secondary (0-12): 12 College (1-4or 5+): 0

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker

16b. Kind of Business/Industry: Her own home

17. Father's Name (First, Middle, Last): Frank Alber

18. Mother's Name (First, Middle, Maiden Surname): Anna Singur

19a. Informant's Name/Relationship (Type, Print): Russell Brousseau - Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 6 Waters Avenue Hicksville, New York 11801

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Hagerstown Crematory

Date: 3/21/2001

20c. Location - City or Town, State: Hagerstown, Maryland

21. Signature of Funeral Service Licensee: Scott Minnich

22. Name and Address of Facility: Minnich Funeral Home 415 E. Wilson Blvd. Hagerstown, Maryland 21740

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Asystole — 1/2 hours

Due to (or as a consequence of):

b. Acute anteroseptal myocardial infarction. — 7 hours

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c. Dyslipidemia and hypertension — undetermined

Due to (or as a consequence of):

d. Age

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☑ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death (Check only one) — Hospital: 1☑ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) — 1☑ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Scott M. Hamilton, MD

29c. License number: D44316

29d. Date signed (Month, Day, Year): 3/19/01

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): 249 Mill Street, Hagerstown, Maryland 21740

State Registrar

31. Date filed (Month, Day, Year): MAR 2 2 2001

32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

Frances A Brousseau

ME: BROUSSEAU,FRANCES ALBER
/12/1921 79 / F

DOS: 03/19/2001

H3042829394

H197310

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 10439

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: ESTHER YVONNE BUCCI
2. Date of Death (Month, Day, Year): March 24 2001
3. Time of Death: 8:10 PM
4a. Facility Name *(If not institution, give street and number)*: 29511 Schwanniger Road
4b. City, Town, or Location of Death: Easton
4c. County of Death: Talbot

Funeral Director

5. Social Security Number: 579 34 4470
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 72 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: Nov 30 1928
9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Talbot
10c. City, Town or Location: Easton
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 29511 Schwanniger Road
10f. Zip Code: 21601
10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* white

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12; College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: artist/ accountant
16b. Kind of Business/Industry: art/ accounting

17. Father's Name *(First, Middle, Last)*: Elmer A. Norris
18. Mother's Name *(First, Middle, Maiden Surname)*: Ottilie Orzech

19a. Informant's Name/Relationship *(Type, Print)*: Frank Bucci- husband
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 29511 Schwanniger Rd. Easton Md. 21601

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Christ Epis. Cemetery
Date: March 29, 2001
20c. Location - City or Town, State: Port Republic MD

21. Signature of Funeral Service Licensee: ▶ B Rausch
22. Name and Address of Facility: Rausch Funeral Home PA 4405 Broomes Is. Rd. Port Republic MD

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Hydrocephalus — years

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Bipolar Diorder

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☒ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day, Year)*
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Carolyn Helmly MD
29c. License number: D0053602
29d. Date signed *(Month, Day, Year)*: 3/26/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Carolyn Helmly, MD Easton Md. 21601

State Registrar

31. Date filed *(Month, Day, Year)*: MAR 28 2001
32. Registrar's Signature: ▶ [signature]

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

16

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 10440

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Viola Evelyn Carter
2. Date of Death Month: March Day: 19 Year: 2001
3. Time of Death: 23:46 M
4a. Facility Name (If not institution, give street and number): Upper Chesapeake Medical Center
4b. City, Town, or Location of Death: Bel Air
4c. County of Death: Harford

Funeral Director

5. Social Security Number: 407-40-4828
6. Sex: 1☐M 2☒F
7. Age (In yrs. last birthday): 64 Yrs.
If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): SEPT 23, 1936
9. Birthplace (State or Foreign Country): Kentucky

Usual Residence of Decedent

10a. State: Maryland
10b. County: Cecil
10c. City, Town or Location: North East
10d. Inside City Limits: 1☒Yes 2☐No
10e. Street and Number: 301 Pennsylvania Avenue
10f. Zip Code: 21901
10g. Citizen of What Country?: United States

11. Marital Status: 1☐Never Married 2☐Married 3☒Widowed 4☐Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐Yes 2☒No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Sales
18b. Kind of Business/Industry: Automobile Retail

17. Father's Name (First, Middle, Last): Glen Mauk
18. Mother's Name (First, Middle, Maiden Surname): Faye Carroll

19a. Informant's Name/Relationship (Type, Print): David B. Carter/Son
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 5 Westover Place, North East, Maryland 21901

20a. Method of Disposition: 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): North East Methodist Cemetery
Date: March 24, 2001
20c. Location - City or Town, State: North East, Maryland

21. Signature of Funeral Service Licensee: John B. Hopkins
22. Name and Address of Facility: Hicks Home for Funerals, P.A. 103 W. Stockton Street, Elkton, Maryland 21921

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line.

Approximeta Intervel Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Pancreatic Cancer — about one year.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐Yes 2☐No 9☐Unknown
23c. If yes, outcome of pregnancy: 1☐Live birth 2☐Fetal death 3☐Ectopic pregnency 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown
23d. Date of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobecco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☒Unknown

24a. Was an autopsy performed? 1☐Yes 2☒No
24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☐No

25. Was case referred to medical examiner? 1☐Yes 2☒No

28. Place of Death (Check only one): Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☐Residence 8☐Other (Specify)

27. Manner of Death: 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐Yes 2☐No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification; To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end menner es stated. 2☐**Medical Examiner:** On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Albert S.C. Sun, M.D.
29c. License number: D-0018779
29d. Date signed (Month, Day, Year): March 20, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): ALBERT S.C. SUN, M.D. 1716 HARFORD ROAD FALLSTON MD 21047

State Registrar

31. Date filed (Month, Day, Year): MAR 23 2001
32. Registrar's Signature: Geneva D. Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23e or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit case.

Viola E Carter

6

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 10441

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Robert Lee Campbell
2. Date of Death Month Day Year: March 26, 2001
3. Time of Death: 2:25 AM
4a. Facility Name *(If not institution, give street and number)*: 480 Crothers Road
4b. City, Town, or Location of Death: Rising Sun
4c. County of Death: Cecil

Funeral Director

5. Social Security Number: 212-30-5701
6. Sex: 1 [X] M 2 [ ] F
7. Age *(In yrs. last birthday)*: 71 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: March 8, 1930
9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Cecil
10c. City, Town or Location: Rising Sun
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 480 Crothers Road
10f. Zip Code: 21911
10g. Citizen of What Country?: United States

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 10 — College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Euclid Operator
16b. Kind of Business/Industry: Quarry

17. Father's Name *(First, Middle, Last)*: unknown
18. Mother's Name *(First, Middle, Maiden Surname)*: Dorothy Campbell

19a. Informant's Name/Relationship *(Type, Print)*: Hazel Campbell / Spouse
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 296 Post Road, Rising Sun, Maryland 21911

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Ebenezer Cemetery — Date: March 28, 2001
20c. Location - City or Town, State: Rising Sun, Maryland

21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: Crouch Funeral Home, 127 South Main Street, North East, Maryland 21901

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Carcinoma of prostate with metastasis — 5yrs.

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Chronic Obstructive Pulmonary disease

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death *(Check only one)*: Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — Other: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other *(Specify)*

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined

28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature] MD
29c. License number: D22307
29d. Date signed *(Month, Day, Year)*: 03/26/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): JAYANTILAL K. PATEL MD 123 Slingerly Ave, ELKTON, MD 21921

State Registrar

31. Data filed *(Month, Day, Year)*: MAR 2 6 2001
32. Registrar's Signature: [signature] D. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 10442

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Mary Callahan

2. Date of Death: Month March Day 25 Year 2001

3. Time of Death: 12 noon M

4a. Facility Name (If not institution, give street and number): Sunbridge Care

4b. City, Town, or Location of Death: Elkton

4c. County of Death: Cecil

Funeral Director

5. Social Security Number: 167-14-0372

6. Sex: 1 ☐ M 2 ☑ F

7. Age (In yrs. last birthday): 93 Yrs.

If Under 1 Year: Months ___ Days ___ If Under 24 Hrs.: Hours ___ Min. ___

8. Date of Birth (Month, Day, Year): February 4, 1908

9. Birthplace (State or Foreign Country): Pennsylvania

Usual Residence of Decedent

10a. State: Maryland

10b. County: Cecil

10c. City, Town or Location: Elkton

10d. Inside City Limits: 1 ☑ Yes 2 ☐ No

10e. Street and Number: 150 E. Main Street

10f. Zip Code: 21921

10g. Citizen of What Country? U.S.A.

11. Marital Status: 1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☑ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 11 College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Housewife

18b. Kind of Business/Industry: Household

17. Father's Name (First, Middle, Last): Thomas Pastuzek

18. Mother's Name (First, Middle, Maiden Surname): Frances Wesolowski

19a. Informant's Name/Relationship (Type, Print): Tim D. Callahan - Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 41 Cornwall Drive, Newark, Delaware 19711

20a. Method of Disposition: 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): R.A. Ferris Crematory

Date: March 27, 2001

20c. Location - City or Town, State: West Chester, Pennsylvania

21. Signature of Funeral Service Licensee: [signature]

22. Name and Address of Facility: Gee Funeral Home 259 E. Main Street, Elkton, Maryland 21921

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Alzheimer's Dementia

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

b. Renal Failure

Due to (or as a consequence of):

c. Chronic Renal Insufficiency

Due to (or as a consequence of):

d. Coronary Artery Disease

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown

23c. If yes, outcome of pregnancy: 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown

23d. Date of delivery: Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Hypoplastic Anemia
Hypothyroidism

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No

28. Place of Death (Check only one): Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☑ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature] MD

29c. License number: H0054380

29d. Date signed (Month, Day, Year): 3/26/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Christine E. K. Horah, D.O. 412 Suburban Plaza, Newark, DE 19711

Medical Certification; To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

10

State Registrar

31. Date filed (Month, Day, Year): MAR 27 2001

32. Registrar's Signature: [signature] B. Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No: 2001 10443

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Lorin Gale Cox

2. Date of Death Month Day Year: March 23/2001

3. Time of Death: 1:15 am

4a. Facility Name *(If not institution, give street and number)*: 27955 Old Village Road

4b. City, Town, or Location of Death: Mechanicsville

4c. County of Death: St. Mary's

Funeral Director

5. Social Security Number: 304-32-6141

6. Sex: 1 [X] M 2 [ ] F

7. Age *(In yrs. last birthday)*: 65 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: May 7, 1935

9. Birthplace *(State or Foreign Country)*: Indiana

Usual Residence of Decedent

10a. State: Maryland

10b. County: St. Mary's

10c. City, Town or Location: Mechanicsville

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 27955 Old Village Road

10f. Zip Code: 20659

10g. Citizen of What Country?: U S A

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12; College (1-4or 5+): 4

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Captain

16b. Kind of Business/Industry: United States Air Force

17. Father's Name *(First, Middle, Last)*: Myron J. Cox

18. Mother's Name *(First, Middle, Maiden Surname)*: Evelona Reese

19a. Informant's Name/Relationship *(Type, Print)*: Alberta J. Cox (Spouse)

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)* 20659: 27955 Old Village Road, Mechanicsville, Maryland

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Crown View Cemetery

Date: 3/29/2001

20c. Location - City or Town, State: Sheridan, Indiana

21. Signature of Funeral Service Licensee: Mary Rizzo

Mary Rizzo MO1114

22. Name and Address of Facility: Brinsfield Funeral Home, P.A.
P.O. Box 279, Leonardtown, Maryland 20650

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Liver Cancer — Four Months

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death *(Check only one)*: Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [X] Residence 8 [ ] Other *(Specify)*

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 8 [ ] Could not be determined

28a. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: SC Gaby MD

29c. License number: D54346

29d. Date signed *(Month, Day, Year)*: 3/27/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Chandra Sajja, M.D. Hollywood, Maryland 20636

State Registrar

31. Date filed *(Month, Day, Year)*: MAR 26 2001

32. Registrar's Signature: Geneva B. Sparks

ORIGINAL

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 28a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

DR

Please Type or Print In Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 10444

Viola Constantino

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Viola Constantino
2. Date of Death: Month MARCH Day 25, Year 2001
3. Time of Death: 2:55 AM M
4a. Facility Name (If not institution, give street and number): CIVISTA MEDICAL CENTER
4b. City, Town, or Location of Death: LA PLATA
4c. County of Death: CHARLES

Funeral Director

5. Social Security Number: 214-46-6853
6. Sex: 1☐M 2☒F
7. Age (In yrs. last birthday): 89 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Jan. 2, 1912
9. Birthplace (State or Foreign Country): Maryland

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: Maryland
10b. County: Charles
10c. City, Town or Location: Waldorf
10d. Inside City Limits: 1☐Yes 2☒No
10e. Street and Number: 5906 Michael Road
10f. Zip Code: 20601
10g. Citizen of What Country?: USA
11. Marital Status: 1☐Never Married 2☐Married 3☒Widowed 4☐Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐Yes 2☒No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No Specify:
14. Race - American Indian, Black, White, etc. Specify: White
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 8; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker
16b. Kind of Business/Industry: Own Home
17. Father's Name (First, Middle, Last): Michael Lipkowski
18. Mother's Name (First, Middle, Maiden Surname): Telfila unavailable
19a. Informant's Name/Relationship (Type, Print): Carol Jarboe - Daughter
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 9270 Crescent Lane, La Plata, MD 20646
20a. Method of Disposition: 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Arlington National Cem. Date: 3-29-01
20c. Location - City or Town, State: Arlington, Virginia
21. Signature of Funeral Service Licensee: Mark G. Brohawn M00053
22. Name and Address of Facility: Huntt Funeral Home P. O. Box 156. Waldorf, MD 20604-0156

Physician /Medical Examiner

Medical Certification; To Be Completed by Physician/Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. METASTATIC CARCINOMA of LUNG. x DAYS
Due to (or as a consequence of):
b. ADVANCED ATHEROSCLEROSIS. x years
Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
c.
Due to (or as a consequence of):
d.

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐Yes 2☒No 9☐Unknown
23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown
23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☒Unknown

24a. Was an autopsy performed? 1☐Yes 2☒No
24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☐No

25. Was case referred to medical examiner? 1☐Yes 2☒No

28. Place of Death (Check only one): Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death: 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐Yes 2☐No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier:
29c. License number: D-0020629
29d. Date signed (Month, Day, Year): 3/25/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): GEORGE H. WATHEN MD 11345 PEMBROOKE SQUARE, SUITE 103, WALDORF, MARYLAND 20603

State Registrar

31. Date filed (Month, Day, Year): MAR 27 2001
32. Registrar's Signature: Brenda G. Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 10445

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Russell G. Crawford
2. Date of Death (Month, Day, Year): March 19, 2001
3. Time of Death: 12:15am
4a. Facility Name *(If not institution, give street and number)*: 7005 Beechmont Drive
4b. City, Town, or Location of Death: Sykesville
4c. County of Death: Carroll

Funeral Director

5. Social Security Number: 216-07-3236
6. Sex: 1☒ M 2☐ F
7. Age *(In yrs. last birthday)*: 86 Yrs. — If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: July 26, 1914
9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residance of Decedant

10a. Stete: MD
10b. County: Carroll
10c. City, Town or Location: Sykesville
10d. Inside City Limits: 1☐ Yas 2☒ No
10e. Street and Number: 7005 Beechmont Drive
10f. Zip Code: 21784
10g. Citizan of What Country?: U.S.A.

11. Maritel Stetus: 1☐ Nevar Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Evar in U.S. Armad Forces? 1☐ Yas 2☒ No If Yas, Giva Year or Datas:
13. Was Decedant of Hispenic Origin? (Specify Yes or No- If Yas, specify Cuban, Maxican, Puarto Rican, etc.): 1☐ Yes 2☒ No *Specify:*
14. Rece - American Indian, Bleck, White, atc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12; College (1-4or 5+):
16a. Decedent's Usual Occupation *(Giva kind of work dona during most of working lifa. DO NOT usa retired)*: Service Repairman
16b. Kind of Businass/Industry: Appliance

17. Fathar's Nama *(First, Middla, Last)*: Frederick Crawford
18. Mothar's Nama *(First, Middla, Maidan Sumama)*: Mary Parrish

19a. Informant's Name/Ralationship *(Type, Print)*: Mrs. Geraldine Crawford (Wife)
19b. Malling Address *(Street and Number or Rural Routa Number, City or Town, State, Zip Code)*: 7005 Beechmont Drive Sykesville, MD 21784

20a. Mathod of Disposition: 1☐ Burial 2☒ Cramation 3☐ Removal from Stata 4☐ Donation 5☐ Othar *(Specify)*
20b. Placa of Disposition *(Nama of cematery, cremetory or othar placa)*: All County Cremation Srv.
Data: 3/21/01
20c. Location - City or Town, Stata: Sykesville, MD

21. Signatura of Funeral Service Licensee: ▶ Brian L. Haight
22. Nama and Address of Facility: HAIGHT FUNERAL HOME & CHAPEL, PA (Box 195) Sykesville, MD 21784 (410)-795-1400

Physician /Medical Examiner

23a. Part1. Entar tha disease, or complications that caused tha daath. Do not antar the moda of dying, such as cardiac or raspiretory errest, shock, or haart failure. List only one ceuse on aech line.

Approximata Intervel Between Onset and Death

Immediata Cause (Final disease or condition resulting in death):
a. Metastatic Carcinoma of Colon & bladder — 5 YRS.
Dua to (or as a consaquance of):
b. COPD
Sequantially list conditions, if any, leading to immadiata causa. Entar Underlying Cause (Disaasa or Injury thet initieted events rasulting in death) Last
Due to (or es a consequance of):
c. CHF.
Due to (or es a consequance of):
d.

Part II. **Other significant conditions** contributing to death but not rasulting in the underlying causa givan in Part I.

23b. Did tobacco use contribute to the cause of death? 1☒ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yas 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was casa rafarred to medical examinar? 1☐ Yas 2☒ No
26. Placa of Death *(Chack only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Homa 5☒ Residanca 6☐ Other *(Specify)*
27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicida 5☐ Pending investigation 6☐ Could not be determined
28a. Data of Injury *(Month, Day Year)*
28b. Tima of Injury
28c. Injury at Work? 1☐ Yas 2☐ No
28d. Describe how injury occurred
28a. Placa of Injury - At home, ferm, street, factory, offica building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Routa Number, City or Town, Stete)*

29a. Cartifier *(Check only one)*: 1☒ **Certifying Physician:** To tha best of my knowledge, death occurred at the time, dete and placa, and dua to the ceuse(s) and manner as stated. 2☐ **Medical Examiner:** On tha basis of axamination and/or invastigation, in my opinion, daath occurred at tha time, date and placa, and dua to the cause(s) and mannar stated.
29b. Signature and title of certifier: ▶ L Pallan, M.D. M.D.
29c. Licensa number: D16206
29d. Data signed *(Month, Day, Year)*: 3/20/2001
30. Nama and address of person who completed causa of death (Item 23a) (Type, Print): E. PALLAN, M.D. 1380 PROGRESS WAY, ELDERSBURG Md 21784

State Registrar

31. Data filed *(Month, Day, Year)*: MAR 22 2001
32. Registrar's Signatura: Geneva G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

WJS 4

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 10446

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Edward Caponio

2. Date of Death: Month 03 Day 14 Year 2001

3. Time of Death: 1:55 AM

4a. Facility Name (If not institution, give street and number): University of Maryland Medical Center

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: Baltimore City

Funeral Director

5. Social Security Number: 225-11-6935

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 40 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Oct 24, 1960

9. Birthplace (State or Foreign Country): Wash. D.C.

Usual Residence of Decedent

10a. State: Virginia

10b. County: Fairfax

10c. City, Town or Location: Alexandria

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 8417 Fort Hunt Road

10f. Zip Code: 22308

10g. Citizen of What Country? U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yas, specify Cuban, Maxican, Puarto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 12

College (1-4or 5+): + 8

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Systems Engineer

16b. Kind of Business/Industry: SAIC

17. Father's Name (First, Middle, Last): Joseph Francis Caponio

18. Mother's Name (First, Middle, Maiden Surname): Virginia S. Hall

19a. Informant's Name/Relationship (Type, Print): Ramona Caponio - Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 8417 Fort Hunt Road, Alexandria, VA 22308

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cematary, crematory or other placa): Mt. Comfort Cemetery

Data: 3/16/01

20c. Location - City or Town, State: Alexandria, VA

21. Signature of Funaral Service Licensee: Diana L. Lewis

22. Name and Address of Facility: DEMAINE FUNEZRAL Home, 520 South Washington Street, Alexandria, VA

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on aach line.

Approximate Intervai Between Onset and Death

Immediate Cause (Finat disaase or condition resulting in death)

a. Cardiopulmonary Arrest

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Central Nervous system Toxoplasmosis

Due to (or as a consequence of):

c. Acute Lymphocytic Leukemia

Due to (or as a consequence of):

d. status post Allogenic stem cell Transplant

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

status post Autologous Stem cell Transplant

Thrombocytopenia

Anemia

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Ware autopsy findings availabie prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one)

Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA

Other: 4 [ ] Nursing Home 5 [ ] Residence 8 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicida 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yas 2 [ ] No

28d. Describe how injury occurred

28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, Stata)

29a. Certifier (Check only one): 1 [X] **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: M.D.

29c. Licensa number: RES000

29d. Date signed (Month, Day, Year): 3/14/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): GARY TIAN, MD. 22 South Greene Street, Baltimore, MD 21201

State Registrar

31. Date filed (Month, Day, Year): MAR 23 2001

32. Registrar's Signature: Brenda G. Hanks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attanding Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

20

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No: 2001 10447

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): James R. Canady
2. Date of Death: Month March Day 9, Year 2001
3. Time of Death: 3:21am

4a. Facility Name (If not institution, give street and number): Washington Adventist Hospital
4b. City, Town, or Location of Death: Takoma Park
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 578-54-1550
6. Sex: 1☒ M 2☐ F
7. Age (In yrs. last birthday): 60 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Jan. 26, 1941
9. Birthplace (State or Foreign Country): Washington, D.C.

Usual Residence of Decedent

10a. State: Maryland
10b. County: Prince George's
10c. City, Town or Location: Mt. Rainier
10d. Inside City Limits: 1☒ Yes 2☐ No

10a. Street and Number: 3308 Otis Street
10f. Zip Code: 20712
10g. Citizen of What Country?: United States

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yeer or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Maintenance Engineer
16b. Kind of Business/Industry: Private

17. Father's Name (First, Middle, Last): Unk
18. Mother's Name (First, Middle, Maiden Surname): Mildred Braxton

19a. Informent's Name/Relationship (Type, Print): James Canady
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2146 Jennings Street Woodbridge, Va. 22191

20a. Method of Disposition: 1☒ Burial 2☐ Cremetion 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Harmony Memorial Park
Date: 3/19/01
20c. Location - City or Town, State: Landover, Md.

21. Signature of Funeral Service Licensee: ▶ Keith A. Savage M01085
22. Name and Address of Facility: Alexander S. Pope Funeral Homes 5538 Marlboro Pike/Forestville, Md. 20747

Physician /Medical Examiner

23a. Part1. Enter the disease or complicetions that caused the death. Do not enter the mode of dying, such es cardiec or respiratory arrest, shock, or heart tailure. List only one cause on eech line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) a.	Hepatic Failure	3 days
Due to (or es e consequence of): b.	Circhosis of the liver	years
Sequentially list conditions, if any, leading to immediete ceuse. Enter Underlying Cause (Disease or Injury that initiated events resulting in deeth) Last — Due to (or es e consequence of): c.	Alcoholic liver Disease	years
d.		

Part II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Pert I.

23b. Did tobacco use contribute to the ceuse of death? 1☒ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was en autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy tindings aveilable prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medicel exeminer? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Netural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Dete of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, dete end place, and due to the cause(s) end manner as steted. 2☐ **Medical Examiner**: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and dua to the cause(s) end menner steted.

29b. Signature and title of certifier: ▶ MD
29c. License number: D-46093
29d. Dete signed (Month, Day, Year): 3/9/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Rodman Mostaghim 7305 Hanover Parkway Greenbelt, MD 20770

State Registrar

31. Dete filed (Month, Day, Year): MAR 19 2001
32. Registrar's Signature: ▶ Geneva G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 28a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

(5)

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 10448

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: John J. Cimino
2. Date of Death Month Day Year: March 17, 2001
3. Time of Death: 6:18 AM
4a. Facility Name *(If not institution, give street and number)*: Doctors Community Hospital
4b. City, Town, or Location of Death: Lanham
4c. County of Death: Prince Georges

Funeral Director

5. Social Security Number: 112-28-9930
6. Sex: 1☒M 2☐F
7. Age *(In yrs. last birthday)*: 72 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: Feb. 21, 1929
9. Birthplace *(State or Foreign Country)*: New York

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: Md.
10b. County: Prince Georges
10c. City, Town or Location: Bowie
10d. Inside City Limits: 1☒Yes 2☐No
10e. Street and Number: 12416 Skylark Lane
10f. Zip Code: 20715
10g. Citizen of What Country?: USA

11. Marital Status: 1☐Never Married 2☒Married 3☐Widowed 4☐Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☒Yes 2☐No If Yes, Give Year or Dates: 1952-1957
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐Yes 2☒No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): — College (1-4or 5+): 2
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Electronic engineer
16b. Kind of Business/Industry: US Gov't

17. Father's Name *(First, Middle, Last)*: Giolando Cimino
18. Mother's Name *(First, Middle, Maiden Surname)*: Concetta Lacara

19a. Informant's Name/Relationship *(Type, Print)*: Rose Cimino Wife
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 12416 Skylark Lane, Bowie, Md. 20715

20a. Method of Disposition: 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Md. Veterans Cemetery — Date: 03-23-01
20c. Location - City or Town, State: Crownsville, Md.

21. Signature of Funeral Service Licensee: Beall
22. Name and Address of Facility: Beall Funeral Home, 6512 N.W. Crain Hwy., Bowie, Md. 20715

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death):
a. MYOCARDIAL INFARCTION — 16 hr
Due to (or as a consequence of):
b. HEART BLOCK — 18 4
Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
c. DIABETES MELLITUS — Years
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: SEPSIS

23b. Did tobacco use contribute to the cause of death? 1☐Yes 2☑No 3☐Probably 4☐Unknown

24a. Was an autopsy performed? 1☐Yes 2☑No

24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☐No

25. Was case referred to medical examiner? 1☐Yes 2☑No

26. Place of Death *(Check only one)*: Hospital: 1☑Inpatient 2☐ER/Outpatient 3☐DOA — Other: 4☐Nursing Home 5☐Residence 6☐Other *(Specify)*

27. Manner of Death: 1☑Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

28a. Date of Injury *(Month, Day, Year)*
28b. Time of Injury
28c. Injury at Work? 1☐Yes 2☐No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

29e. Certifier *(Check only one)*: 1☑**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Sudhakar Rump
29c. License number: D0020072
29d. Date signed *(Month, Day, Year)*: 3/19/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): 7219 HANOVER PARKWAY GREENBELT MD 20770

(15)

State Registrar

31. Date filed *(Month, Day, Year)*: MAR 19 2001
32. Registrar's Signature: Donna B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 10449

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Willie E. Coleman

2. Date of Death (Month, Day, Year): March 20, 2001

3. Time of Death: 8:10 AM

4a. Facility Name (If not institution, give street and number): Prince George's Hospital Center

4b. City, Town, or Location of Death: Cheverly

4c. County of Death: Prince George's

Funeral Director

5. Social Security Number: 251-60-1514

6. Sex: 1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday): 64 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): November 1, 1936

9. Birthplace (State or Foreign Country): South Carolina

Usual Residence of Decedent

10a. State: Maryland

10b. County: Prince George's

10c. City, Town or Location: District Heights

10d. Inside City Limits: 1 ☒ Yes 2 ☐ No

10e. Street and Number: 2020 Brooks Drive Apt. #506

10f. Zip Code: 20747

10g. Citizen of What Country? U.S.A.

11. Marital Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 9th grade

College (1-4or 5+):

18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): D.C. Cab Driver

16b. Kind of Business/Industry: Yellow Cab Company

17. Father's Name (First, Middle, Last): R.C. Coleman

18. Mother's Name (First, Middle, Maiden Surname): Annie Suber

19a. Informant's Name/Relationship (Type, Print): Mrs. Adrienne M. Coleman (Wife)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2020 Brooks Drive Apt. #506 District Heights, Maryland 20747

20a. Method of Disposition: 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Chesapeake Crematory, Inc.

Date: 3/21/01

20c. Location - City or Town, State: Beltsville, Maryland

21. Signature of Funeral Service Licensee: Janet C. Anderson

22. Name and Address of Facility: Rollins Funeral Home, Inc. 4339 Hunt Place, N.E. Washington, D.C. 20019

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

23e. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. ISCHEMIC ENCEPHALOPATHY — 2 YRS

Due to (or as a consequence of):

b. MULTIPLE CEREBROVASCULAR ACCIDENTS — 3 YRS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c. PRIMARY CARDIAC ARREST

Due to (or as a consequence of):

d. DILATED CARDIOMYOPATHY

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

CORONARY ARTERY DISEASE

INSULIN DEPENDENT DIABETES

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury M

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1 ☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: David A. Goorey DO. MD.

29c. License number: D28195

29d. Date signed (Month, Day, Year): 03-21-01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): DAVID A. GOORAY. MD. 11450 MERCANTILE LN. LARGO. MD.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

(4)

State Registrar

31. Date filed (Month, Day, Year): MAR 21 2001

32. Registrar's Signature: Bernice G. Sparks

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 10450

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Robert J. Clark
2. Date of Death: Month March Day 21 Year 2001
3. Time of Death: 7:15 P.M.
4a. Facility Name (If not institution, give street and number): 3831 Eaves Lane
4b. City, Town, or Location of Death: Mitchellville
4c. County of Death: Prince Georges

Funeral Director

5. Social Security Number: 307-30-5847
6. Sex: 1☒ M 2☐ F
7. Age (In yrs. last birthday): 68 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Aug. 24, 1932
9. Birthplace (State or Foreign Country): Indiana

Usual Residence of Decedent

10a. State: Md.
10b. County: Prince Georges
10c. City, Town or Location: Bowie
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 3831 Eaves Lane
10f. Zip Code: 20716
10g. Citizen of What Country? USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 11 / College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Printer
16b. Kind of Business/Industry: Printing
17. Father's Name (First, Middle, Last): William M. Clark
18. Mother's Name (First, Middle, Maiden Surname): Marie B. Barker
19a. Informant's Name/Relationship (Type, Print): Arlene Clark Wife
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3831 Eaves Lane, Bowie, Md. 20716
20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Metropolitan Crematory Date: 03-22-01
20c. Location - City or Town, State: Alexandria, VA.
21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: Beall Funeral Home 6512 N.W. Crain Hwy., Bowie, Md. 20715

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

CR

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Lung cancer — 10 months

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last: b. ; Due to (or as a consequence of): ; c. ; Due to (or as a consequence of): ; d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☒ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day, Year)
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

29a. Certifier (Check only one): 1☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature]
29c. License number: D20352
29d. Date signed (Month, Day, Year): Mar. 22, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Harvey I. Katzen MD, 7525 Greenway Center Dr., Greenbelt, Md.20770

(4)

State Registrar

31. Date filed (Month, Day, Year): MAR 22 2001
32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 10451

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)			2. Date of Death Month / Day / Year	3. Time of Death
Ana	Rosa	Cuevas	03-16-2001	3:01 AM M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Holy Cross Hospital	Silver Spring	Montgomery

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
599-38-3668	1☐ M 2☒ F	82 Yrs.			02-27-1918	Dominican Rep.

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Md	Mont.	Silver Spring	1☒ Yes 2☐ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
4002 Sampson Road	20906	U.S.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced	1☐ Yes 2☒ No If Yes, Give Year or Dates:	☒ Yes 2☐ No Specify: Dom. Republic	Specify:

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	18b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
0		Housewife	N/A

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Juan Cuevas	Ana Ventura

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Ilrana Figueroa (daughter)	4002 Sampson Road, Silver Spring, Md 20906

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)	Las Salinas Sal y Yesp	03-24-01	Santo Dimingo

21. Signature of Funeral Service Licensee

22. Name and Address of Facility: Austin Royster Funeral Home, 3821 14th Street, NW, Wash. DC 20011

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	Respiratory Arrest	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to (or as a consequence of): Cardiovascular Pulmonary Disease	
	b. Due to (or as a consequence of):	
	c. Due to (or as a consequence of):	
	d.	

If FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month / Day / Year
1☐ Yes 2☐ No 9☐ Unknown	1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) 9☐ Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Hypertention

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐ Yes 2☒ No	1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

28. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☒ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? 1☐ Yes 2☐ No	28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification; To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
	D53528	March 19, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Daphna Henkin, MD
2309 Shenfield Road, Wheaton, MD 20902

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
MAR 20 2001	G. Sparks

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 17 Rev 1/2001

ORIGINAL

RKD

01-1402-031

JOSEPH CSAJI

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar Amend #4b, 3/19/2001, BMW, Montg. Co

Certificate of Death

Reg. No. 2001 10452

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month / Day / Year	3. Time of Death
Joseph Stephen Csaji, Jr.	MARCH 12, 2001	6:15P. M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
17609 OLNEY LANE	ROCKVILLE ~~OLNEY~~	MONTGOMERY

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
220-72-5128	1☒M 2☐F	39 Yrs.			August 25, 1961	Maryland

Usual Residence of Decedent

10e. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Montgomery	Rockville	1☐Yes 2☒No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
17609 Olney Lane	20853	United States

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐Never Married 2☒Married 3☐Widowed 4☐Divorced	1☐Yes 2☒No If Yes, Give Year or Dates:	1☐Yes 2☒No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12		Owner	HVAC Company

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Joseph Stephen Csaji, Sr.	Irene Chetneky

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Anne M. Csaji/Wife	17609 Olney Lane, Rockville, Maryland 20853

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	Potomac United Methodist Church Cemetery	March 17, 2001	Potomac, Maryland

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
John P. Chapelis	Robert A. Pumphrey Funeral Home/Rockville, Inc. 300 West Montgomery Avenue, Rockville, Maryland 20850-2805

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	e. Carbon Monoxide Intoxication	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of):	
	c. Due to (or as a consequence of):	
	d. Due to (or as a consequence of):	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month / Day / Year
1☐Yes 2☐No 9☐Unknown	1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) _____ 9☐Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☒Yes 2☐No	1☒Yes 2☐No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☒Yes 2☐No	Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA	Other: 4☐Nursing Home 5☐Residence 6☒Other (Specify) SCENE

27. Manner of Death	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☐Natural 2☐Accident 3☒Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined	3/12/01	VNK M	1☐Yes 2☒No	Subject inhaled exhaust fumes

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)
AT HOME	17609 Olney Lane 20855

29a. Certifier (Check only one) 1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☒ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
[signature]	O.C.M.E.	MARCH 13, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

J. Aaron Locke MD 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
MAR 19 2001	[signature]

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than 'natural', or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

31

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 10453

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): James J. Crider
2. Date of Death (Month, Day, Year): March 13, 2001
3. Time of Death: 10:25 AM

4a. Facility Name (If not institution, give street and number): Washington Adventist Hospital
4b. City, Town, or Location of Death: Takoma Park
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 577-32-5018
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 74 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Dec.8,1926
9. Birthplace (State or Foreign Country): Washington,DC

Usual Residence of Decedent

10a. State: DC
10b. County: none
10c. City, Town or Location: Washington,DC
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 2862 28th St.,NW
10f. Zip Code: 20008
10g. Citizen of What Country?: USA

11. Marital Status: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: 1942-1945
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puarto Rican, etc.): 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: white

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): | College (1-4or 5+): 4
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Accountant
16b. Kind of Business/Industry: Non-Profit

17. Father's Name (First, Middle, Last): Rana A. Crider
18. Mother's Name (First, Middle, Maiden Surname): Teresa H. Dampf

19a. Informant's Name/Relationship (Type, Print): Howard F. Didsbury/friend
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2862 28th St.,NW.,Washington,DC 20008-4110

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, cremetory or other place): Metropolitan Crematory | Date: Mar.16, 2001
20c. Location - City or Town, State: Alexandria, Va.

21. Signature of Funeral Service Licensee: John F. DeVol
22. Name and Address of Facility: DeVol Funeral Home 2222 Wisconsin Ave.,NW.,Washington,DC 20007

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or raspiratory arrest, shock, or haart failure. List only one cause on each line. | Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. CARDIOPULMONARY ARREST
Due to (or as a consequence of):
b. PNEUMONIA
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c. SEPTICEMIA
Due to (or as a consequence of):
d. ACUTE RENAL FAILURE

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No
26. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner es stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: MD
29c. License number: D46529
29d. Date signed (Month, Day, Year): 3/13/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): VICTOR ONYEJIAKA 7375A HANOVER PARKWAY GREENBELT MARYLAND

State Registrar

31. Date filed (Month, Day, Year): MAR 20 2001
32. Registrar's Signature: B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

10

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 10454

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Helen V. Crandall
2. Date of Death (Month, Day, Year): March 20, 2001
3. Time of Death: 1850
4a. Facility Name *(If not institution, give street and number)*: Shady Grove Adventist Hospital
4b. City, Town, or Location of Death: Rockville
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 040-12-4209
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 85 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: April 20, 1915
9. Birthplace *(State or Foreign Country)*: Connecticut

Usual Residence of Decedent

10a. State: Maryland
10b. County: Montgomery
10c. City, Town or Location: Montgomery Village
10d. Inside City Limits: 1☐ Yes 2☒ No
10a. Street and Number: 9833 Dellcastle Road
10f. Zip Code: 20886
10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White
15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 / College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Sales Person
16b. Kind of Business/Industry: Department Store
17. Father's Name *(First, Middle, Last)*: Joseph Belz
18. Mother's Name *(First, Middle, Maiden Surname)*: Anna Kus
19a. Informant's Name/Relationship *(Type, Print)*: Kendra A. Jemmott/Daughter
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 9833 Dellcastle Road, Montgomery Village, MD 20886
20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: All Saints Cemetery — Date: Mar. 26 2001
20c. Location - City or Town, State: North Haven, Connecticut
21. Signature of Funeral Service Licensee: David E. Peery. M00803
22. Name and Address of Facility: Robert A. Pumphrey Funeral Home/ Rockville, Inc. 300 West Montgomery Avenue Rockville, Maryland 20850-2805

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Acute Myocardial Infarction
Due to (or as a consequence of):
b. Congestive Heart Failure
Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
c. Pneumonia
Due to (or as a consequence of):
d. Urinary Tract Infection

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
Renal Failure
Hypertension

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death *(Check only one)*: Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*
27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29e. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Vinu Ganti
29c. License number: D41162 MD
29d. Date signed *(Month, Day, Year)*: March 21, 2001
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): V. Ganti MD 19529 Doctors Drive Germantown MD 20874

State Registrar

31. Date filed *(Month, Day, Year)*: MAR 23 2001
32. Registrar's Signature: Diane B. Sparks

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Division of Vital Records, P.O. Box 68760,

10

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 10455

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): BEATRICE M. COY

2. Date of Death (Month, Day, Year): MARCH 8, 2001

3. Time of Death: 11:55AM

4a. Facility Name (If not institution, give street and number): HOLY CROSS HOSPITAL

4b. City, Town, or Location of Death: SILVER SPRING

4c. County of Death: MONTGOMERY

Funeral Director

5. Social Security Number: 262-32-7066

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 77 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): MARCH 5, 1924

9. Birthplace (State or Foreign Country): OHIO

Usual Residence of Decedent

10a. State: MARYLAND

10b. County: MONTGOMERY

10c. City, Town or Location: KENSINGTON

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 2610 MCCOMAS AVENUE

10f. Zip Code: 20895

10g. Citizen of What Country?: UNITED STATES

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Evar in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedant of Hispanic Origin? (Specify Yas or No- If Yas, specify Cuban, Maxican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highast grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): SECRETARY

16b. Kind of Business/Industry: BANKING

17. Father's Name (First, Middle, Last): HAROLD STALNAKER

18. Mother's Name (First, Middle, Maiden Surnama): HALLIE MARIE SMITH

19a. Informant's Name/Relationship (Type, Print): NORMA JEAN DOWD / DAUGHTER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2610 MCCOMAS AVENUE, KENSINGTON, MD 20895

20a. Method of Disposition: 1☐ Burial 2☐ Cremation 3☒ Ramoval from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other placa): WOODLAWN MEMORIAL PARK | Date: 03/13/01

20c. Location - City or Town, State: ORLANDO, FLORIDA

21. Signature of Funaral Service Licensee: ▶ Donald C. Stottlemyer

22. Name and Address of Facility: DANZANSKY GOLDBERG MEMORIAL CHAPEL, INC. 1170 ROCKVILLE PIKE, ROCKVILLE, MD 20852

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

D.C. or Virginia Price

6/5

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or haart failure. List only ona cause on each line. | Approximate Interval Between Onset and Death

Immediate Cause (Final disaase or condition resulting in death)
a. RESPIRATORY FAILURE — FEW MINUTES

Due to (or as a consequance of):
b. PNEUMONIA

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c. CHRONIC OBSTRUCTIVE PULMONARY DISEASE

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

OBESITY

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year): N/A

28b. Time of Injury: M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred: N/A

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify): N/A

28f. Location (Street and Number or Rural Route Number, City or Town, State): N/A

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

12

29a. Certifier (Check only one): 1☒ Certifying Physician: To the bast of my knowledge, death occurred at the time, date and placa, and due to the cause(s) and manner es stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at tha time, date and placa, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Viatti Anthony

29c. License number: D0051158

29d. Date signed (Month, Day, Year): 03/05/2001

30. Name end address of person who completed cause of death (Item 23a) (Type, Print): Viatti Anthony, M.D. 2401 RESEARCH BLVD #102 ROCKVILLE MD 20850

State Registrar

31. Date filed (Month, Day, Year): MAR 20 2001

32. Registrar's Signature: ▶ Geneva G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 10456

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): James Rexford Coleman
2. Date of Death (Month, Day, Year): March 21, 2001
3. Time of Death: 1445
4a. Facility Name (If not institution, give street and number): MCHS - Potomac
4b. City, Town, or Location of Death: Potomac
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 002-18-1810
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 77 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 03-21-1924
9. Birthplace (State or Foreign Country): New York

Usual Residence of Decedent

10a. State: MD
10b. County: Montgomery
10c. City, Town or Location: Rockville
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 14517 Manor Park Drive
10f. Zip Code: 20853
10g. Citizen of What Country?: United States

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No — If Yes, Give Year or Dates: 1941-1943
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexicen, Puerto Rican, etc.): 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indien, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondery (0-12): — College (1-4or 5+): 5+
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Medical Doctor
16b. Kind of Business/Industry: Private Practice

17. Father's Name (First, Middle, Last): John Edward Coleman
18. Mother's Name (First, Middle, Maiden Surname): Marion Merchant

19a. Informent's Name/Relationship (Type, Print): Peter Coleman / Son
19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code): 10605 Boswell Lane Potomac, MD 20854

20a. Method of Disposition: 1 [ ] Burial 2 [ ] Cremation 3 [ ] Removel from State 4 [X] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Anatomic Gift Fnd. — Date: 3/21/01
20c. Location - City or Town, State: Laurel, MD
21. Signeture of Funerel Service Licensee: ▶ B + O
22. Name end Address of Facility: Anatomic Gift Foundation 8948 Baltimore Ave. Laurel, MD 20707

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory errest, shock, or heart failure. List only one ceuse on each line.

		Approximete Interval Between Onset and Death
Immediete Cause (Final disease or condition resulting in death)	a. massive upper gastrointestinal hemorrhage	24hrs
Due to (or as a consequence of):	b. erosive esophagitis	2 wks
Sequentially list conditions, if any, leading to immediete cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	c. gastro esophageal reflux disease	20yrs
Due to (or as a consequence of):	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Part I.: cerebrovascular disease with multiple cerebrovascular accidents

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown
24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No
25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No
26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpetient 3 [ ] DOA — Other: 4 [X] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)
27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)
29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, dete end plece, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of axamination and/or investigation, in my opinion, death occurred at the time, dete end plece, end due to the ceuse(s) and manner stated.
29b. Signature and title of certifier: ▶ George F. Sengstack MD
29c. License number: D12121
29d. Date signed (Month, Day, Year): March 21, 2001
30. Name and address of person who completed ceuse of death (Item 23a) (Type, Print): Dr. George F. Sengstack 3929 Ferrara Dr. Wheaton, MD 20906

State Registrar

31. Date filed (Month, Day, Year): MAR 29 2001
32. Registrar's Signature: ▶ Donna B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 10457

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Rose Cohen
2. Date of Death (Month, Day, Year): March 16 2001
3. Time of Death: 8:55 AM
4a. Facility Name (If not institution, give street and number): Potomac Valley Nursing Home
4b. City, Town, or Location of Death: Rockville
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 087-07-4948
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 89 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Jan. 11, 1912
9. Birthplace (State or Foreign Country): Palestine

Usual Residence of Decedent

10a. State: Maryland
10b. County: Montgomery
10c. City, Town or Location: Rockville
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 1235 Potomac Valley Rd.
10f. Zip Code: 20854
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 8 | College (1-4or 5+):
16a. Decedent's Usuet Occupation (Give kind of work done during most of working life. DO NOT use retired): Seamstress
16b. Kind of Business/Industry: Ladies Garments

17. Father's Neme (First, Middle, Last): Abraham Levy
18. Mother's Neme (First, Middle, Maiden Surname): Rebecca Bezalel

19a. Informant's Neme/Relationship (Type, Print): Sheila Iseman - Daughter
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 8800 Quiet Stream Ct. Potomac, MD 20854

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, cremetory or other piece): Mount Hebron
Date: 3/18/01
20c. Location - City or Town, State: Flushing, Queens, NY

21. Signature of Funeral Service Licensee: ▶ Dennis A. Bulbin
22. Name and Address of Facility: Capitol Funeral Service 5517 Vine Street Alexandria, Virginia

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications thet caused the death. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heart feilure. List only one cause on eech line. (Approximate Interval Between Onset and Death)

Immediate Cause (Final disease or condition resulting in death):
a. Urinary Tract Infection
Due to (or as a consequence of):
b. Chronic Obstructive Pulmonary Disease
Due to (or es a consequence of):
c. Congestive Heart Failure
Due to (or es a consequence of):
d. Dementia

Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Wes an autopay performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Netural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, airest, fectory, office building, etc. (Specify)
28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) and manner es stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ S. Hanjura
29c. License number: D43272
29d. Date signed (Month, Day, Year): 3/16/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Sunita Hanjura, M.D. 809 Viers Mill Rd. Rockville, MD 20851

State Registrar

31. Date filed (Month, Day, Year): MAR 19 2001
32. Registrer's Signature: ▶ G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 10458

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): ROSE COHAN
2. Date of Death (Month, Day, Year): MARCH 15, 2001
3. Time of Death: 10:15 Am
4a. Facility Name (If not institution, give street and number): 1909 ALABASTER ROAD
4b. City, Town, or Location of Death: SILVER SPRING
4c. County of Death: MONTGOMERY

Funeral Director

5. Social Security Number: 215-44-3567
6. Sex: 1 ☐ M 2 ☒ F
7. Age (In yrs. last birthday): 93 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): MARCH 11, 1908
9. Birthplace (State or Foreign Country): MARYLAND

Usual Residence of Decedent

10a. State: MARYLAND
10b. County: MONTGOMERY
10c. City, Town or Location: SILVER SPRING
10d. Inside City Limits: 1 ☐ Yes 2 ☒ No
10e. Street and Number: 1909 ALABASTER ROAD
10f. Zip Code: 20904
10g. Citizen of What Country?: UNITED STATES

11. Marital Status: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 ☐ Yes 2 ☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): SECRETARY
16b. Kind of Business/Industry: FEDERAL GOVERNMENT

17. Father's Name (First, Middle, Last): ABRAHAM POLLEKOFF
18. Mother's Name (First, Middle, Maiden Surname): SONIA MOISHE

19a. Informant's Name/Relationship (Type, Print): DR. ALLAN B. COHEN / SON
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 11021 EDISON ROAD, POTOMAC, MD 20854

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): KING DAVID MEMORIAL GARDENS | Date: 03/18/01
20c. Location - City or Town, State: FALLS CHURCH, VA

21. Signature of Funeral Service Licensee: ▶ [signature]
22. Name and Address of Facility: DANZANSKY GOLDBERG MEMORIAL CHAPEL, INC 1170 ROCKVILLE PIKE, ROCKVILLE, MD 20852

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. (Approximate Interval Between Onset and Death)

Immediate Cause (Final disease or condition resulting in death)
a. CVA
Due to (or as a consequence of):
b. Cerebral Arteriosclerosis

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☑ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No
26. Place of Death (Check only one): Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☑ Other (Specify) ASSISTED LIVING

27. Manner of Death: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: ▶ [signature]
29c. License number: D04549
29d. Date signed (Month, Day, Year): 3/18/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): ALAN B. COHEN, MD 13925 CONN. AVE. S. S. MD. 20906

State Registrar

31. Date filed (Month, Day, Year): MAR 21 2001
32. Registrar's Signature: ▶ [signature] B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 10459

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Mary Rose Cogliano
2. Date of Death (Month, Day, Year): March 16, 2001
3. Time of Death: 7:10 am
4a. Facility Name *(If not institution, give street and number)*: Holy Cross Hospital
4b. City, Town, or Location of Death: Silver Spring
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 100-07-7439
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 83 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: Feb 28, 1918
9. Birthplace *(State or Foreign Country)*: New York

Usual Residence of Decedent

10a. State: Maryalnd
10b. County: Montgomery
10c. City, Town or Location: Rockville
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 4404 Kalmia Street
10f. Zip Code: 20853
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No — If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondery (0-12): 12 — College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Seamstress
16b. Kind of Business/Industry: New York Garment District

17. Father's Name *(First, Middle, Last)*: Carlo DiIorio
18. Mother's Name *(First, Middle, Maiden Surname)*: Pasqualina Orsogna

19a. Informant's Name/Relationship *(Type, Print)*: Carmine Cogliano / Husband
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 4404 Kalmia Street, Rockville, MD 20853

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Gate of Heaven Cemetery — Date: Mar 19 2001
20c. Location - City or Town, State: Silver Spring, MD

21. Signature of Funeral Service Licensee: ▶ Andrew J. Cole
22. Name and Address of Facility: Francis J. Collins Funeral Home, Inc. 500 University Blvd., W, Silver Spring, MD 20901

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) a.	Respiratory Failure	immediate
Due to (or as a consequence of): b.	Aspiration Pneumonia	4 days
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last — Due to (or as a consequence of): c.		
Due to (or as a consequence of): d.		

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Prosthetic Hip infection

Inanition

Decubitus

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 8☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Ira Paul Kreiling MD
29c. License number: D21435
29d. Date signed *(Month, Day, Year)*: March 16, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): IRA PAUL KREILING 2101 Medical Park Drive Silver Spring, 20902

State Registrar

31. Date filed *(Month, Day, Year)*: MAR 19 2001
32. Registrar's Signature: ▶ Donna G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 10460

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Lois E. Clow
2. Date of Death — Month: March Day: 17 Year: 2001
3. Time of Death: 4 10 pm
4a. Facility Name *(If not institution, give street and number)*: Mercy Hospital
4b. City, Town, or Location of Death: Baltimore
4c. County of Death:

Funeral Director

5. Social Security Number: 028 24 8543
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 67 Yrs. — If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: October 3, 1933
9. Birthplace *(State or Foreign Country)*: Massachusetts

Usual Residence of Decedent

10a. State: Florida
10b. County: Sarasota
10c. City, Town or Location: Long Boat Key
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 3804 Gulf of Mexico Drive
10f. Zip Code: 34228
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)* — Elementary/Secondary (0-12): 12 / College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Ticket Agent
16b. Kind of Business/Industry: Air Line

17. Father's Name *(First, Middle, Last)*: Robert Burton Airey
18. Mother's Name *(First, Middle, Meiden Surname)*: Flora Paul

19a. Informant's Name/Relationship *(Type, Print)*: Albert Clow/Husband
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 3804 Gulf of Mexico Drive, Long Boat Key, FL 34228

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Metropolitan Crematory — Date: Mar 19 2001
20c. Location - City or Town, State: Alexandria, Virginia

21. Signature of Funeral Service Licensee: John E. Parker
22. Name and Address of Facility: Francis J. Collins Funeral Home, Inc. 500 University Blvd.,W.,Silver Spring,MD 20901

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode ot dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Sepsis syndrome — days
Due to (or as a consequence of): OVARIAN CARCINOMA — months

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: OsteoArthritis, hypothyroidism

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No
26. Place of Death *(Check only one)* — Hospital: 1☑ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 8☐ Other *(Specify)*

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)* 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Nevins W Todd MD
29c. License number: D37790
29d. Date signed *(Month, Day, Year)*: March 17, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Nevins W Todd M.D. 301 St. Paul Place Baltimore MD 21202

State Registrar

31. Date filed *(Month, Day, Year)*: MAR 19 2001
32. Registrar's Signature: B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 10461

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Phyllis Jean Choate
2. Date of Death (Month, Day, Year): March 22, 2001
3. Time of Death: 6:30 am
4a. Facility Name (If not institution, give street and number): 3333 University Blvd., W, Apt 706
4b. City, Town, or Location of Death: Kensington
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 519-26-7642
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 75 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Apr 10, 1925
9. Birthplace (State or Foreign Country): Idaho

Usual Residence of Decedent

10a. State: Maryland
10b. County: Montgomery
10c. City, Town or Location: Kensington
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 3333 University Blvd., W, Apt 706
10f. Zip Code: 20895
10g. Citizen of What Country: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): | College (1-4or 5+): 1
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker
16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): Neal Vaughan
18. Mother's Name (First, Middle, Maiden Surname): Lois Terry

19a. Informant's Name/Relationship (Type, Print): Larry L. Choate / Son
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4713 Mount Zion Road, Frederick, MD 21703

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Metropolitan Crematory | Date: Mar 22 2001
20c. Location - City or Town, State: Alexandria , VA

21. Signature of Funeral Service Licensee: John E. Parker
22. Name and Address of Facility: Francis J. Collins Funeral Home, Inc. 500 University Blvd., W, Silver Spring, MD 20901

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Breast Cancer — 7 years

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b.

Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Stephen Staal MD
29c. License number: D 18219
29d. Date signed (Month, Day, Year): March 22, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Stephen Staal, MD 10810 Connecticut Ave., Kensington, MD 20895

State Registrar

31. Date filed (Month, Day, Year): MAR 23 2001
32. Registrar's Signature: Donna G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 10462

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: KWAI-KUN CHEUNG

2. Date of Death Month: MARCH Day: 16 Year: 2001

3. Time of Death: 2144

4a. Facility Name *(If not institution, give street and number)*: SUBURBAN HOSPITAL

4b. City, Town, or Location of Death: BETHESDA

4c. County of Death: MONTGOMERY

Funeral Director

5. Social Security Number: 578-90-6651

6. Sex: 1☒ M 2☐ F

7. Age *(In yrs. last birthday)*: 80 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: June 8, 1920

9. Birthplace *(State or Foreign Country)*: China

Usual Residence of Decedent

10a. State: Maryland | 10b. County: Montgomery | 10c. City, Town or Location: Rockville | 10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 12101 Otis Drive | 10f. Zip Code: 20852 | 10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* Chinese

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 6 | College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Tailor

16b. Kind of Business/Industry: Clothing

17. Father's Name *(First, Middle, Last)*: San Yuen Cheung

18. Mother's Name *(First, Middle, Maiden Surname)*: Not Available

19a. Informant's Name/Relationship *(Type, Print)*: Pin Sing Cheung/Son

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 10503 Smithy Court, North Potomac, Maryland 20878

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Gate of Heaven Cemetery | Date: March 24, 2001

20c. Location - City or Town, State: Silver Spring, Maryland

21. Signature of Funeral Service Licensee: Robert Pumphrey M00198

22. Name and Address of Facility: Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue Bethesda, Maryland 20814-3501

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): e. ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: CHRONIC RENAL FAILURE; REPAIR AV-GRAFT LFT. THIGH

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☒ Yes 2☐ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☒ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)* | 28b. Time of Injury M | 28c. Injury at Work? 1☐ Yes 2☐ No | 28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)* | 28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier *(Check only one)*: 1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☒ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: MD (ONE)

29c. License number: D15236

29d. Date signed *(Month, Day, Year)*: MARCH 17, 2001

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): CARL I. MARGOLIS, MD. 11125 ROCKVILLE PIKE, ROCKVILLE, MD 20852

State Registrar

31. Date filed *(Month, Day, Year)*: MAR 19 2001

32. Registrar's Signature: Bruce B. Sparks

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filed in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 10463

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: CLARA C. CHAMBERS

2. Date of Death Month / Day / Year: MARCH 22 2001

3. Time of Death: 9:20 AM

4a. Facility Name *(If not institution, give street and number)*: KINGSHIRE MANOR NURSING HOME

4b. City, Town, or Location of Death: ROCKVILLE

4c. County of Death: MONTGOMERY

Funeral Director

5. Social Security Number: 162-16-9945

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 96 Yrs. | If Under 1 Yaar: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Sept.21,1904

9. Birthplace *(State or Foreign Country)*: Pennsylvania

Usual Residence of Decedent

10a. State: Virginia

10b. County: Fairfax

10c. City, Town or Location: Alexandria

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 5911 Reservoir Heights Ave.

10f. Zip Code: 22311

10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Dacedent Evar in U.S. Armed Forcas? 1☐ Yes 2☒ No If Yes, Give Year or Datas:

13. Was Decedent of Hispanic Origin? (Specify Yas or No- If Yes, specify Cuban, Mexican, Puarto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Blcck, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 | Collega (1-4or 5+): 0

16a. Decedent's Usuel Occupetion *(Give kind of work done during most of working life. DO NOT use retired)*: Homemaker

16b. Kind of Business/Industry: Own Home

17. Fathar's Neme *(First, Middle, Last)*: William Grover Critchfield

18. Mother's Neme *(First, Middle, Maiden Surname)*: Sarah Mae Herbert

19a. Interment's Neme/Reletionship *(Type, Print)*: David Kramer / Nephew

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 20134 Torrey Pond Pl.,Montgomery Village,Md. 20886

20a. Method ot Disposition: 1☒ Buriel 2☐ Cremetion 3☐ Ramovel from Stete 4☐ Donetion 5☐ Other *(Specify)*

20b. Piece of Disposition *(Neme of cemetery, cremetory or other piece)*: LaFayette Memorial Park

Date: 3/26/01

20c. Location - City or Town, Stete: Redstone Twp., Pa.

21. Signature of Funeral Service licensee: John Barber

22. Name and Address ot Facility: Muriel H. Barber Funeral Home, P. O. Box 5038, Laytonsville, Md. 20882

Physician /Medical Examiner

23a. Part I. Enter the diseese, or complications thet caused the death. Do not enter the mode ot dying, such as cardiac or respiratory arrest, shock, or heert feilure. List only ona ceusa on eech line.

Approximate Interval Between Onset and Death

Immediete Cause (Final disease or condition resulting in death)

a. CONGESTIVE HEART FAILURE

Due to (or as e consequence ot):

Sequentially list conditions, if eny, leeding to immediete cause. Enter Underlying Ceuse (Diseese or Injury thet initieted events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or es e consequence ot):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: DEMENTIA

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

24a. Was en eutopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy tindings aveilable prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical exeminer? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpetient 3☐ DOA | Other: 4☒ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined

28a. Dete of Injury *(Month, Dey Year)*

28b. Time of Injury M

28c. Injury et Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Piece of Injury - At home, ferm, street, tectory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred et the time, date end piece, end due to the cause(s) and menner as stated. 2☐ **Medical Examiner:** On the basis of exeminetion and/or investigetion, in my opinion, deeth occurred et the time, date end place, and dua to the cause(s) and menner steted.

29b. Signeture and title of certifier: [signature]

29c. License number: D-0054566

29d. Dete signed *(Month, Day, Year)*: MARCH 22, 2001

30. Nama and address of person who completed cause of death (Item 23a) (Type, Print): SUNITHA BHOGAVILLI, M.D. 15225 SHADY GROVE RD., ROCKVILLE, MARYLAND 20850

State Registrar

31. Dete tiled *(Month, Day, Year)*: MAR 23 2001

32. Registrer's Signeture: [signature]

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

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To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

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Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Amend #20b, 3/23/2001, BMW, Montg. Co.

Certificate of Death

Reg. No. 2001 10464

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): George Alexander Care

2. Date of Death (Month, Day, Year): March 17, 2001

3. Time of Death: 4:45 AM.

4a. Facility Name (If not institution, give street and number): Collingswood Nursing Home

4b. City, Town, or Location of Death: Rockville

4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 067-16-4475

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 81 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Mar. 31, 1919

9. Birthplace (State or Foreign Country): Pennsylvania

Usual Residence of Decedent

10a. State: Maryland

10b. County: Montgomery

10c. City, Town or Location: Potomac

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 12102 Greenleaf Ave.

10f. Zip Code: 20854

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No. If Yes, Give Year or Dates: WW11

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): | College (1-4or 5+): 4

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Electrical Engineer

16b. Kind of Business/Industry: Transportation

17. Father's Name (First, Middle, Last): Jacob Sabatovic

16. Mother's Name (First, Middle, Maiden Surname): Mary Sijarak

19a. Informant's Name/Relationship (Type, Print): Helen J. Care Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 12102 Greenleaf Ave., Potomac, Md. 20854

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Arlington NAtional Cem

Date: 3/30/2001

20c. Location - City or Town, State: Arlington, Va.

21. Signature of Funeral Service Licensee: W. Arthur Murray

22. Name and Address of Facility: Joseph Gawler's Sons, Inc. 5130 Wisc. Ave. NW., Washington, D.C. 20016

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0020

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Pneumonia

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last: b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [X] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: K R Lillie MD

29c. License number: D53244

29d. Date signed (Month, Day, Year): March 17, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Katharine R. Lillie, MD 11140 Rockville Pike, PMB 348, Rockville, MD 20852

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

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State Registrar

31. Date filed (Month, Day, Year): MAR 20 2001

32. Registrar's Signature: Donna G. Sparks

DHMH 16 Rev 6/95

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 10465

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Norah M. AKA Nora M. Cahill / Cahill

2. Date of Death Month Day Year: March 22, 2001

3. Time of Death: 2:00 am

4a. Facility Name *(If not institution, give street and number)*: 6220 42nd Avenue

4b. City, Town, or Location of Death: Hyattsville

4c. County of Death: Prince George's

Funeral Director

5. Social Security Number: 577-22-5437

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 88 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Dec 20, 1912

9. Birthplace *(State or Foreign Country)*: Ireland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Prince George's

10c. City, Town or Location: Hyattsville

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 6220 42nd Avenue

10f. Zip Code: 20781

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 / College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Homemaker

16b. Kind of Business/Industry: Own Home

17. Father's Name *(First, Middle, Last)*: John Brosnan

18. Mother's Name *(First, Middle, Maiden Surname)*: Catherine Dowling

19a. Informant's Name/Relationship *(Type, Print)*: Richard Cahill / Husband

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 6220 42nd Avenue, Hyattsville, MD 20781

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Gate of Heaven Cemetery

Date: Mar 26 2001

20c. Location - City or Town, State: Silver Spring, MD

21. Signature of Funeral Service Licensee: William J Byrd

22. Name and Address of Facility: Francis J. Collins Funeral Home, Inc. 500 University Blvd., W, Silver Spring, MD 20901

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Atherosclerosis

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Peripheral Vascular Disease

Due to (or as a consequence of):

c. Hypertension

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☒ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Mark K Li MD

29c. License number: D 27865

29d. Date signed *(Month, Day, Year)*: March 22, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Mark K. Li, MD 1721 University Blvd., W, Wheaton, MD 20902

State Registrar

31. Date filed *(Month, Day, Year)*: MAR 23 2001

32. Registrar's Signature: Donna G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 10466

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Frederick A. Brewer
2. Date of Death Month / Day / Year: March 20, 2001
3. Time of Death: 5:00 am
4a. Facility Name *(If not institution, give street and number)*: 2201 Colston Drive Apt 508
4b. City, Town, or Location of Death: Silver Spring
4c. County of Death: MONTGOMERY

Funeral Director

5. Social Security Number: 493-09-9369
6. Sex: 1 [X] M 2 [ ] F
7. Age *(In yrs. last birthday)*: 93 Yrs.
If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: Aug 28, 1907
9. Birthplace *(State or Foreign Country)*: Missouri

Usual Residence of Decedent

10a. State: Maryland
10b. County: Montgomery
10c. City, Town or Location: Silver Spring
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 2201 Colston Drive Apt 508
10f. Zip Code: 20910
10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: 1943-1945
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12; College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Photo Engraver
16b. Kind of Business/Industry: Private

17. Father's Name *(First, Middle, Last)*: Frederick Brewer
18. Mother's Name *(First, Middle, Maiden Surname)*: Unknown

19a. Informant's Name/Relationship *(Type, Print)*: Marie N. Brewer/ Wife
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 2201 Colston Drive, Silver Spring, MD 20910

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: MD Veteran's Cemetery
Date: Mar 22 2001
20c. Location - City or Town, State: Cheltenham, MD

21. Signature of Funeral Service Licensee: ▶ J. Kein Stiles
22. Name and Address of Facility: Francis J. Collins Funeral Home, Inc. 500 University Blvd., W, Silver Spring, MD 20901

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Atherosclerotic Heart Disease — 5 years

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Chronic Renal Failure

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No
26. Place of Death *(Check only one)*: Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; Other: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other *(Specify)*

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury *(Month, Day, Year)*
28b. Time of Injury
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: ▶ Alan Weinstock M.D.
29c. License number: D09748
29d. Date signed *(Month, Day, Year)*: March 20, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Alan Weinstock, MD 10313 Georgia Ave., Silver Spring, MD 20902

State Registrar

31. Date filed *(Month, Day, Year)*: MAR 21 2001
32. Registrar's Signature: ▶ Donna G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 10467

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Doris Loretta Irene Brewster

2. Date of Death Month Day Year: March 16, 2001

3. Time of Death: 10:10 AM

4a. Facility Name *(If not institution, give street and number)*: Casey House

4b. City, Town, or Location of Death: Rockville

4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 302-50-0669

6. Sex: 1☐ M 2☒ F

7. Age *(in yrs. last birthday)*: 48 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Data of Birth *(Month, Day, Year)*: Aug. 3, 1952

9. Birthplace *(State or Foreign Country)*: Georgia

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: Maryland

10b. County: Montgomery

10c. City, Town or Location: Gaithersburg

10d. Inside City Limits: 1☐ Yes 2☒ No

10a. Street and Number: 9 Prairie Rose Court

10f. Zip Code: 20878

10g. Citizen of What Country?: United States

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☒ Yes 2☐ No If Yes, Give Year or Dates: 1978-2001

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* Black

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12) / College (1-4or 5+): 5+

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Chief Master Sergeant

16b. Kind of Business/Industry: U.S. Air Force

17. Father's Name *(First, Middle, Last)*: Marvin P. Brewster

18. Mother's Name *(First, Middle, Maiden Surname)*: Lula Mae Bridges

19a. Informant's Name/Relationship *(Type, Print)*: Brandon E. G. Hicks / Son

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 9 Prairie Rose Ct. Gaithersburg, MD 20878

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Arlington National Cem.

Date: 4/10/01

20c. Location - City or Town, State: Arlington, Virginia

21. Signature of Funeral Service Licensee ▶ [signature]

22. Name and Address of Facility: Hines-Rinaldi Funeral Home, Inc. 11800 New Hampshire Ave. Silver Spring, MD 20904

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Metastatic Carcinoma — 5 Months

Due to (or as a consequence of):
Colon Cancer — 5 Months

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Pleural Effusion

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☒ Other *(Specify)* Hospice

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier ▶ E. P. Libre MD

29c. License number: D09470

29d. Date signed *(Month, Day, Year)*: March 16, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Eugene P. Libre, M.D. 10400 Connecticut Avenue Kensington, MD 20895

State Registrar

31. Date filed *(Month, Day, Year)*: MAR 21 2001

32. Registrar's Signature ▶ Donna B. Sparks

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

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DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar Amend #28c, 3/20/2001, GF, Mont.Co. **Certificate of Death** Reg. No. 2001 10468

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month / Day / Year	3. Time of Death
ANTHONY BOHORFOUSH	MARCH, 14 2001	06:55 AM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
SHOCK TRAUMA, UNIVERSITY OF MD	BALTIMORE, CITY	BALTIMORE, CITY

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
704-14-5978	1 [X] M 2 [ ] F	98 Yrs.			July 18, 1902	Alabama

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Prince George's	Beltsville	1 [ ] Yes 2 [X] No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
11331 Montgomery Road	20705	United States

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced	1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:	1 [ ] Yes 2 [X] No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	18b. Kind of Business/Industry
Elementary/Secondary (0-12) 12	College (1-4or 5+)	Vice President	Southern Railroad

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
George Bohorfoush	Susan Joseph

19e. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Walter L. Bohorfoush - son	same as #10a - 10g

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	Gate of Heaven Cemetery	3/17/2001	Silver Spring, Maryland

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
Matthew S Brown	Donald V. Borgwardt Funeral Home, P.A. 4400 Powder Mill Rd. Beltsville, Maryland 20705

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. UREMIA	7 dy
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Renal Failure - progressive	2 yrs
	c.	
	d.	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month / Day / Year
1 [ ] Yes 2 [ ] No 9 [ ] Unknown	1 [ ] Live birth 2 [ ] Fetal death 3 [ ] Ectopic pregnancy 4 [ ] Pregnant at time of death 5 [ ] Other (specify) 9 [ ] Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Dementia

23e. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1 [ ] Yes 2 [X] No	1 [ ] Yes 2 [ ] No

Medical Certification: To Be Completed by Physician/Medical Examiner

25. Was case referred to medical examiner?	28. Place of Death (Check only one)	
1 [ ] Yes 2 [X] No	Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA	Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death	28e. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined		M	1 [ ] Yes 2 [X] No	
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
Kerry Kole DO	H0055103	MARCH, 14, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Kerry Kole, 22 South Broome Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
MAR 20 2001	Teresa B. Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23e or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

GF

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

2001 10469
Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death (Month, Day, Year)	3. Time of Death
Rose Steck Berman	March 20, 2001	6:00 P.M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Suburban Hospital	Bethesda	Montgomery

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
168-30-7699	1☐M 2☒F	92 Yrs.			July 14, 1908	Poland

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Montgomery	Rockville	1☒Yes 2☐No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
6121 Montrose Road	20852	United States

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐Never Married 2☐Married 3☒Widowed 4☐Divorced	1☐Yes 2☒No If Yes, Give Year or Dates:	1☐Yes 2☒No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12	2	Self employed - owner	retail gift shop

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Jacob Steck	Bella Saltz

19a. Informent's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Dorothy Goldklang Gardner - niece	8109 Paisley Place Potomac, Maryland 20854

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	King David Memorial Garden	3/25/01	Falls Church, Virginia

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ Donald V. Borgwardt	Donald V. Borgwardt Funeral Home, P.A. 4400 Powder Mill Rd. Beltsville, Maryland 20705

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Pneumonia	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of):	
	c. Due to (or as a consequence of):	
	d. Due to (or as a consequence of):	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery (Month, Day, Year)
1☐Yes 2☑No 9☐Unknown	1☐Live birth 2☐Fetel death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Dementia
Diabetes Mellitus
Coronary Artery Disease

23e. Did tobacco use contribute to the cause of death?	24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐Yes 2☐No 3☐Probably 4☑Unknown	1☐Yes 2☑No	1☐Yes 2☑No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐Yes 2☑No	Hospital: 1☑Inpatient 2☐ER/Outpatient 3☐DOA	Other: 4☐Nursing Home 5☐Residence 8☐Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☑Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined		M	1☐Yes 2☐No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1☑**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner es stated.
2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ KR Lillie MD	D53244	March 20, 2001

30. Name end address of person who completed cause of death (Item 23a) (Type, Print)
Katharine R. Lillie, MD 11140 Rockville Pike, PMB 348, Rockville, MD 20852

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
MAR 23 2001	▶ Donna G. Sparks

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

Rose S. Berman 6:00 pm 03/20/01

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DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Amend #28c, 3/21/2001, EMW, Montg.Co.

Certificate of Death

Reg. No. 2001 10470

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)			2. Date of Death Month	Day	Year	3. Time of Death
JOYCE	A.	BENOIT	MARCH	18,	2001	3:25 AM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
GENESIS ELDER CARE NURSING HOME	LAPLATA	CHARLES

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months	Days	If Under 24 Hrs.: Hours	Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
014-24-4062	1☐ M 2☒ F	70 Yrs.					DEC. 1, 1930	MASSACHUSETTS

Usual Residence of Decedent

10a. Stete	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD.	CHARLES	HUGHESVILLE	1☒ Yas 2☐ No

10e. Street and Number	10f. Zip Coda	10g. Citizen of What Country?
7580 SO BUSY PL.	20637	U.S.A.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yas or No- If Yes, specify Cuban, Maxican, Puerto Rican, etc.)	14. Race - Americen Indian, Bleck, White, etc.
1☐ Nevar Married 2☐ Married 3☒ Widowed 4☐ Divorced	1☐ Yas 2☒ No If Yes, Give Year or Dates:	1☐ Yes 2☒ No Specify:	Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elemantary/Secondary (0-12)	College (1-4or 5+)		
8		HOUSEWIFE	HOME

17. Fether's Name (First, Middle, Last)	18. Mother's Nama (First, Middle, Meiden Surneme)
EDWARD J. CASS	MARIE PILON

19e. Informant's Name/Reletionship (Type, Print)	19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
SHARON CURTIN/DAUGHTER	1735 CANAL RUN DR., POINT OF ROCKS, MD. 21777

20a. Method of Disposition	20b. Piece of Disposition (Neme of cemetery, cremetory or other piece)	Date	20c. Location - City or Town, State
1☒ Burial 2☐ Cremetion 3☐ Removal from State 4☐ Donetion 5☐ Othar (Specify)	MARYLAND VETERANS CEMETERY	3/26/01	CHELTENHAM, MD.

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
W.W. Chambers	5801 CLEVELAND AVE. M00091 CHAMBERS FUNERAL HOMES, P.A., RIVERDALE, MD. 20737

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications thet ceused the death. Do not enter the mode ot dying, such as cerdiac or respiretory arrest, shock, or heert teilure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immedlete Cause (Final disease or condition resulting in death)	a. ACUTE Respiratory Failure	
	Due to (or as a consequence of):	
Sequentielly list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury thet initieted events resulting in death) Last	b. Congestive Heart Failure	
	Due to (or es a consequence of):	
	c.	
	Due to (or es e consequence of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Part I.

Pneumonia
Chronic Renal Failure

23b. Did tobacco use contribute to the cause of death?	24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of causa of death?
1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown	1☐ Yes 2☑ No	1☐ Yes 2☐ No

25. Was case referred to medical exeminer?	26. Place of Death (Check only one)	
1☐ Yes 2☒ No	Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA	Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Dey Year)	28b. Time of Injury	28c. Injury at Work?	28d. Dascribe how injury occurred
1☒ Natural 2☐ Accident 3☐ Suicida 4☐ Homicida 5☐ Pending investigetion 6☐ Could not be determined		M	1☐ Yes 2☐ No	

28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify)

28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)

29e. Certifier (Check only one)
1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date end piece, end due to the ceuse(s) end manner es stated.
2☐ **Medical Examiner:** On the besis of examination and/or investigation, in my opinion, death occurred at the time, dete end place, and due to the ceuse(s) end manner stated.

29b. Signature end title of certifier	29c. License number	29d. Deta signed (Month, Day, Year)
	D0046241	3/19/01

30. Name and address of person who completed ceuse of death (Item 23a) (Type, Print)
4801 KENMORE AVE #102 ALEXANDRIA VA 22304 ROMALDO DESOUZA, M.D.

State Registrar

31. Dete filed (Month, Dey, Year)	32. Registrer's Signeture
MAR 21 2001	B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 10471

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): JULIA JEANNE BAILEY
2. Date of Death Month Day Year: MARCH 20, 2001
3. Time of Death: 6:15 PM
4a. Facility Name (If not Institution, give street and number): 3161 FLINTHILL ROAD
4b. City, Town, or Location of Death: ADAMSTOWN
4c. County of Death: FREDERICK

Funeral Director

5. Social Security Number: 218-38-8309
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 85 Yrs. | If Under 1 Yaar: Months / Deys | If Under 24 Hrs.: Hours / Min.
8. Data of Birth (Month, Dey, Year): June 9 1915
9. Birthpleca (State or Foreign Country): Indiana

Usuel Residence of Decedent

10a. State: Maryland
10b. County: Montgomery
10c. City, Town or Location: Gaithersburg
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 417 Christopher Avenue, #21
10f. Zip Code: 20879
10g. Citizan of What Country?: United States

11. Maritai Status: 1☐ Nevar Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forcas? 1☐ Yas 2☒ No If Yes, Give Yaer or Detas:
13. Was Decedent of Hispenic Origin? (Specify Yas or No- If Yes, specify Cuban, Maxican, Puarto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Rece - Amarican Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | Collega (1-4or 5+): 2
16a. Decedent's Usual Occupation (Giva kind of work done during most of working life. DO NOT use retired): Secretary
16b. Kind of Business/Industry: School

17. Fathar's Name (First, Middle, Last): Claude C. Baumgardner
18. Mother's Neme (First, Middle, Meiden Surneme): Rosalie H. Carpenter

19a. Informent's Neme/Reletionship (Type, Print): Horace C. Bailey / Husband
19b. Melling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 417 Christopher Ave., #21, Gaithersburg, Md 20879

20a. Mathod of Disposition: 1☐ Burial 2☒ Cremetion 3☐ Removal from Stata 4☐ Donation 5☐ Other (Specify)
20b. Pleca of Disposition (Name of cematary, crematory or other plece): Metropolitan Crematory
Dete: 3/21/01
20c. Location - City or Town, Stata: Alexandria, Virginia

21. Signeture of Funerel Service Licensee: Muriel H. Barber
22. Name and Address of Feciliity: Muriel H. Barber Funeral Home, P. O. Box 5038, Laytonsville, Md. 20882

Physician /Medical Examiner

23a. Part1. Enter the diseese, or complications that caused the death. Do not enter the mode of dying, such es cardiec or respiretory arrest, shock, or heert feilure. List only ona causa on aach line. — Approximate Interval Between Onset and Death

Immediete Ceuse (Finel disease or condition resulting in deeth):
a. Cerebral Infarction
Due to (or as a consequence of):
b. Cardiac Embolus
Due to (or as a consequence of):
c. Atrial fibrillation
Due to (or as a consequance of):
d.

Sequentielly list conditions, if any, leeding to immediete cause. Enter Underlying Cause (Diseese or Injury that Initieted events resulting in deeth) Last

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Wes an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Wes case referred to medical examinar? 1☐ Yas 2☑ No
26. Placa of Deeth (Check only one): Hospitel: 1☐ Inpatient 2☑ ER/Outpetient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residance 8☒ Other (Specify) SON'S HOME

27. Menner of Deeth: 1☑ Netural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending invastigetion 8☐ Could not be detarmined
28e. Dete of Injury (Month, Dey Year)
28b. Time of Injury M
28c. injury et Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28a. Piece of Injury - At home, ferm, street, factory, offica building, etc. (Specify)
28f. Location (Street end Number or Rural Route Number, City or Town, State)

29e. Certifiar (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, daath occurred at the time, dete end placa, end due to the ceuse(s) and menner as steted. 2☐ **Medical Examiner:** On the basis of examinetion end/or investigetion, in my opinion, deeth occurred at the time, date end place, end due to the cause(s) and menner steted.

29b. Signature and title of certifier:
29c. License number: H0045306
29d. Dete signed (Month, Day, Year): MARCH 21, 2001

30. Neme and eddress of person who completed cause of death (Item 23e) (Type, Print): Richard Leschek, DO, 172 Thomas Johnson Drive #100 Frederick MD 21702

State Registrar

31. Dete filed (Month, Day, Year): MAR 23 2001
32. Registrer's Signeture: D. Sparks

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 28a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 10472

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Rouholamin Bahramsoltani
2. Date of Death (Month, Day, Year): March 21, 2001
3. Time of Death: 9:15 AM
4a. Facility Name (If not institution, give street and number): 13713 Willow Tree Drive
4b. City, Town, or Location of Death: Rockville
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 102-70-7094
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 87 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Dec. 6, 1913
9. Birthplace (State or Foreign Country): Iran

Usual Residence of Decedent

10a. State: Maryland
10b. County: Montgomery
10c. City, Town or Location: Rockville
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 13713 Willow Tree Drive
10f. Zip Code: 20850
10g. Citizen of What Country?: Iran

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): | College (1-4or 5+): 5+
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Vice President
16b. Kind of Business/Industry: Bank

17. Father's Name (First, Middle, Last): Yadolah Mirza Bahramsoltani
18. Mother's Name (First, Middle, Maiden Surname): Keshvar Mostofi

19a. Informant's Name/Relationship (Type, Print): Azita B. Lehrenbaum/Daughter
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 13713 Willow Tree Drive, Rockville, Maryland 20850

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Parklawn Memorial Park | Date: Mar. 25 2001
20c. Location - City or Town, State: Rockville, Maryland

21. Signature of Funeral Service Licensee: David E. Perry. M00803
22. Name and Address of Facility: Robert A. Pumphrey Funeral Home/ Rockville, Inc. 300 West Montgomery Avenue Rockville, Maryland 20850-2805

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. (Approximate Interval Between Onset and Death)

Immediate Cause (Final disease or condition resulting in death)
a. Pneumonia
Due to (or as a consequence of):
b.
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
Chronic Obstructive Pulmonary Disease

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [X] Probably 4 [ ] Unknown
24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? [X] Yes 2 [ ] No
26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [X] Residence 8 [ ] Other (Specify)
27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: Anushiravan Dadgar
29c. License number: H51280
29d. Date signed (Month, Day, Year): March 21, 2001
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Anushiravan Dadgar, 13219 Executive Park Terrace, Germantown, Maryland 20874

State Registrar

31. Date filed (Month, Day, Year): MAR 23 2001
32. Registrar's Signature: Steven B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 28a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

ADMEND ITEMS: #20B-C PER ANATOMY BOARD G794 4-4-01 WR

Certificate of Death

Reg. No. 2001 10473

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)			2. Date of Death Month	Day	Year	3. Time of Death
JEAN	BROWNE	CONNORS	February	3	2001	1426

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
PENINSULA REGIONAL MEDICAL CENTER	SALISBURY	WICOMICO

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months	Days	If Under 24 Hrs.: Hours	Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
186-16-9505	1☐ M 2☒ F	78 Yrs.					9-4-22	N.J.

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD.	WORCESTER	OCEAN PINES	1☒ Yes 2☐ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
42 NEWPORT DRIVE	21811	U.S.A.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced	1☐ Yes 2☒ No If Yes, Give Year or Dates:	1☐ Yes 2☒ No Specify:	Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12		MANAGER	CATHOLIC CHARITIES

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
JAMES H. BROWN	KATHERINE B. WALSH

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
TIMOTHY CONNORS	3912 REGENCY PKWY APT. 201 SUITLAND, MD. 207

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☐ Burial 2☐ Cremation 3☐ Removal from State 4☒ Donation 5☐ Other (Specify)	STATE ANATOMY BOARD	2/5/01	

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ [signature]	ULLRICH FUNERAL HOME BERLIN, MD. 21811

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Cardiogenic Shock	
	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	b. Coronary Artery Disease	
	Due to (or as a consequence of):	
	c.	
	Due to (or as a consequence of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐ Yes 2☒ No	1☐ Yes 2☐ No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐ Yes 2☒ No	Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA	Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how Injury occurred
1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined		M	1☐ Yes 2☐ No	
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. Licensa number	29d. Date signed (Month, Day, Year)
▶ [signature]	D55658	2/5/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

FRANK AVENA, M.D. 400 E. Shore Dr. SALISBURY, MD 21804

State Registrar

31. Data filed (Month, Day, Year)	32. Registrar's Signature
FEB 06 2001	[signature] G. Sparks

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

WORCESTER 186-16-9505 Jean Connors 20 20C 5

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 10474

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)			2. Date of Death Month Day Year	3. Time of Death
John	Robert	Drury, Jr.	March 27, 2001	7:00 A M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
21530 Hunters Retreat Lane	Leonardtown	St. Mary's

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
217-32-2132	1 [X] M 2 [ ] F	71 Yrs.			Feb. 5, 1930	Maryland

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	St. Mary's	Leonardtown	1 [ ] Yes 2 [X] No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
21530 Hunters Retreat Lane	20650	U S A

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced	1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:	1 [ ] Yes 2 [X] No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12th Grade		Insurance Salesman	Insurance Company

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
John Robert Drury, Sr.	Mary Rosa Greenwell

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20650
Joseph Drury (Son)	21530 Hunters Retreat Lane, Leonardtown, Maryland

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, cremetory or other place)	Date	20c. Location - City or Town, State
1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	Our Ladys Cemetery	3/30/2001	Leonardtown, Maryland

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ Edward N. Brinsfield, JR. M00052	Brinsfield Funeral Home, P.A. P.O. Box 279, Leonardtown, Maryland 20650

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode ol dying, such es cardiec or respiratory arrest, shock, or heert failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. ATherosclerotic Cardiovascular Disease Sec

Sequentially list conditions, if eny, leading to immediete cause. Enter Underlying Cause (Disease or Injury thet initiated events resulting in death) Last

Due to (or es e consequence of):

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

IF FEMALE: 23b. Wes decedent pregnent in the past 12 months? 1 [ ] Yes 2 [ ] No 9 [ ] Unknown	23c. If yes, outcome ol pregnancy 1 [ ] Live birth 2 [ ] Fetel death 3 [ ] Ectopic pregnancy 4 [ ] Pregnant at time of death 5 [ ] Other (specify) 9 [ ] Unknown	23d. Dete of delivery Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

- Diabetes Mellitus
- Parkinson's Disease

23e. Did tobecco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probebly 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No	24b. Were autopsy findings available prior to completion of cause ol death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

28. Place of Death (Check only one)

Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA

Other: 4 [ ] Nursing Home 5 [X] Residence 8 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? 1 [ ] Yes 2 [ ] No	28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29e. Certifier (Check only one): 1 [X] Certifying Phyalcian: To the best ol my knowledge, deeth occurred et the time, dete and place, and due to the cause(s) and manner as steted. 2 [ ] Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ [signature]	D14285	3-28-01

30. Neme and address of person who completed cause of death (Item 23a) (Type, Print)

William Boyd, II, M.D. Leonardtown, Maryland 20650

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
MAR 29 2001	[signature]

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 10475

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Robert Allen Dean

2. Date of Death (Month, Day, Year): March 24, 2001

3. Time of Death: 11:21 pm

4a. Facility Name *(If not institution, give street and number)*: St. Mary's Hospital

4b. City, Town, or Location of Death: Leonardtown

4c. County of Death: St. Mary's

Funeral Director

5. Social Security Number: 209-24-6999

6. Sex: 1 [X] M 2 [ ] F

7. Age *(In yrs. last birthday)*: 68 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Oct. 28, 1932

9. Birthplace *(State or Foreign Country)*: Pennsylvania

Usual Residence of Decedent

10a. State: North Carolina

10b. County:

10c. City, Town or Location: Charlotte

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 6110 Channing Court

10f. Zip Code: 28215

10g. Citizen of What Country?: U S A

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12th Grade; College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Maintenance/Equipment

16b. Kind of Business/Industry: I B M

17. Father's Name *(First, Middle, Last)*: Howard Arthur Dean

18. Mother's Name *(First, Middle, Maiden Surname)*: Rachel Mary Focht

19a. Informant's Name/Relationship *(Type, Print)*: Michael J. Dean (Son)

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 44454 Moss Court, Callaway, Maryland 20620

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Brinsfield-Echols

Date: 3/27/2001

20c. Location - City or Town, State: Charlotte Hall, MD

21. Signature of Funeral Service Licensee: Edward N. Brinsfield, Jr. M00052

22. Name and Address of Facility: Brinsfield Funeral Home, P.A. P.O. Box 279, Leonardtown, Maryland 20650

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Myocardial Infarction — Sec

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Diabetes Mellitus

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [X] Yes 2 [ ] No

26. Place of Death *(Check only one)*: Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [X] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other *(Specify)*

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury *(Month, Day, Year)*

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred: —

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 [ ] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [X] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: William Boyd II

29c. License number: D14285

29d. Date signed *(Month, Day, Year)*: 3-26-01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): William Boyd, II, M.D. Leonardtown, Maryland 20650

State Registrar

31. Date filed *(Month, Day, Year)*: MAR 26 2001

32. Registrar's Signature: [signature]

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 10476

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Thomas Bernard Dent, Sr.

2. Date of Death: Month: March; Day: 18; Year: 2001

3. Time of Death: 12:35PM

4a. Facility Name *(If not institution, give street and number)*: Stella Maris Hospice

4b. City, Town, or Location of Death: Lutherville - Timonium

4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 220-26-5268

6. Sex: 1☒M 2☐F

7. Age *(In yrs. last birthday)*: 77 Yrs.

If Under 1 Year: Months; Days

If Under 24 Hrs.: Hours; Min.

8. Date of Birth *(Month, Day, Year)*: Sept. 16, 1923

9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Carroll

10c. City, Town or Location: Westminster

10d. Inside City Limits: 1☒Yes 2☐No

10e. Street and Number: 76 Ralph St.

10f. Zip Code: 21157

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐Never Married 2☐Married 3☒Widowed 4☐Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☒Yes 2☐No If Yes, Give Year or Dates: W W II

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* Black

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 7; College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: meat cutter

16b. Kind of Business/Industry: meat packing co.

17. Father's Name *(First, Middle, Last)*: Bernard Dent

18. Mother's Name *(First, Middle, Maiden Surname)*: Nanny Tolbert

19a. Informant's Name/Relationship *(Type, Print)*: Jenneffer Robinson/ daughter

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 10 Charles St. Westminster, MD 21157

20a. Method of Disposition: 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: St. James Cemetery

Date: 3/24/01

20c. Location - City or Town, State: New Windsor, MD

21. Signature of Funeral Service Licensee: Catherine O. Hartzler

22. Name and Address of Facility: Hartzler Funeral Home, 6 E. Broadway, Union Bridge, MD 21791

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. GASTRIC CANCER

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☒Unknown

24a. Was an autopsy performed? 1☐Yes 2☒No

24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☐No

25. Was case referred to *medical examiner*? 1☐Yes 2☒No

28. Place of Death *(Check only one)*: Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA; Other: 4☐Nursing Home 5☐Residence 6☒Other *(Specify)* HOSPICE

27. Manner of Death: 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury

28c. Injury at Work? 1☐Yes 2☐No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒**Certifying Physician:** To the best of *my* knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number: D43725

29d. Date signed *(Month, Day, Year)*: 3/20/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): DR. TARIQ MAHMOOD 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093

State Registrar

31. Date filed *(Month, Day, Year)*: MAR 26 2001

32. Registrar's Signature: Geneva G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

MARCH 18, 2001 12:35 p.m.

THOMAS DENT

WJL 8

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

1- For State Registrar

Reg. No. 2001 10477

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month / Day / Year	3. Time of Death
F. JEROME DOUGHERTY	March 19 2001	1815 M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Upper Chesapeake Medical Center	Bel Air	Harford

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
217-22-4101	1 XX 2 F	81 Yrs.			9/3/1919	Maryland

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	Harford	Pylesville	1 Yes 2 XX No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
137 Constitution Road	21132	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1 Never Married 2 XX Married 3 Widowed 4 Divorced	1 Yes XX No If Yes, Give Year or Dates:	1 Yes XX No Specify:	Specify White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
	1	Dairy Farmer	Agriculture

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Francis J. Dougherty	Carrie C. Donaven

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Margaret H. Dougherty-wife	137 Constitution Rd.Pylesville,MD 21132

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
XX Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)	St. Mary's Cemetery	3/22/01	Pylesville,MD

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ [signature]	Harkins F.H.Inc.,600 MainSt.,Delta,PA 17314

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month / Day / Year
1 Yes 2 No 9 Unknown	1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify) 9 Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

DEMENTIA

23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 XX Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1 Yes 2 XX No	1 Yes 2 No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1 Yes 2 XX No	Hospital: 1 XX Inpatient 2 ER/Outpatient 3 DOA	Other: 4 Nursing Home 5 Residence 6 Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1 XX Natural 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined		M	1 Yes 2 No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1 XX Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ VMAbhyankar MD	D25027	MARCH 20, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

VIJAY M. ABHYANKAR 2 NORTH AVE BEL AIR MD 21014

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
MAR 22 2001	[signature]

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

JM

Dougherty Francis

15

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Amend # 7.Per FH PGC 3-23-01 cr

Certificate of Death

Reg. No. 2001 10478

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Ida V. Dixon

2. Date of Death: Month 3 Day 09 Year 01

3. Time of Death: 1:15 PM

4a. Facility Name (If not institution, give street and number): Gardenview Nursing Facility

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: —

Funeral Director

5. Social Security Number: 224-30-0347

6. Sex: 1☐ M 2☑ F

7. Age (In yrs. last birthday): ~~81~~ 80 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): 05-05-1920

9. Birthplace (State or Foreign Country): Virginia

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: MD | 10b. County | 10c. City, Town or Location: Baltimore | 10d. Inside City Limits: 1☑ Yes 2☐ No

10e. Street and Number: 1217 West Fayette | 10f. Zip Code: 21217 | 10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☑ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☑ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☑ No Specify:

14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): Unknown | College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Domestic

16b. Kind of Business/Industry: Private

17. Father's Name (First, Middle, Last): Willie Barton

18. Mother's Name (First, Middle, Maiden Surname): Ida Virginia Fields

19a. Informant's Name/Relationship (Type, Print): Paula Dixon

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): (5309) 909 Streeper St; Baltimore MD 21205

20a. Method of Disposition: 1☑ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, cremetory or other place): Roosevelt Memorial | Date: 3/16

20c. Location - City or Town, State: Chesapeake, VA

21. Signature of Funeral Service Licensee: [signature] MD-01257

22. Name and Address of Facility: Bianchi Funeral Service 814 Upshur St NW Washington, DC 20011

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Respiratory Failure next dependent

Due to (or as a consequence of):
b. Cancer of Stomach

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Gastrocutaneous Fistula
Multiple duodenitis ulcers

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☑ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year) | 28b. Time of Injury M | 28c. Injury at Work? 1☐ Yes 2☐ No | 28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature] MD

29c. License number: D39127

29d. Date signed (Month, Day, Year): 3/21/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): A. Ahmed 821 N. Eutaw Street Baltimore MD 21201

State Registrar

31. Date filed (Month, Day, Year): MAR 23 2001

32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 10479

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Lois O'Connor Dockery

2. Date of Death: Month MARCH Day 21 Year 2001

3. Time of Death: 10:15PM

4a Facility Name (If not institution, give street and number): Doctors Community Hospital

4b. City, Town, or Location of Death: Lanham

4c. County of Death: Prince Georges

Funeral Director

5. Social Security Number: 578-14-6650

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 80 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Nov. 10, 1920

9. Birthplace (State or Foreign Country): Wash. D.C.

Usual Residence of Decedent

10a. State: Md.

10b. County: Prince Georges

10c. City, Town or Location: Landover Hills

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 3810 73rd Avenue

10f. Zip Code: 20784

10g. Citizen of What Country? USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Data:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker

16b. Kind of Business/Industry: Own home

17. Father's Name (First, Middle, Last): Harvey Alexander O'Connor

18. Mother's Name (First, Middle, Maiden Surname): Wilhemina Hooker

19a. Informant's Name/Relationship (Type, Print): Darrell L. Dockery son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 13709 Heatherstone Dr., Bowie, Md. 20720

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Cedar Hill Cemetery

Date: 03-24-01

20c. Location - City or Town, State: Suitland, Md.

21. Signature of Funeral Service Licensee: Beall

22. Name and Address of Facility: Beall Funeral Home, 6512 N.W. Crain Hwy., Bowie, Md. 20715

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. aspiration pneumonia

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Pancytopenia

Due to (or as a consequence of):

c. primary biliary cirrhosis

Due to (or as a consequence of):

d. Renal insufficiency

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Malnutrition

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Master Sonde, MD

29c. License number: D050514

29d. Date signed (Month, Day, Year): 3/22/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): MEHRU MASTER SONDE, MD 6510 Kenilworth ave. Suite 210 Riverdale MD 20737

State Registrar

31. Date filed (Month, Day, Year): MAR 22 2001

32. Registrar's Signature: Brenda G. Sparks

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

Dockery, Lois O'Connor

CR

20

DHMH 16 Rev 6/95

ORIGINAL

01-1533-033
PHYLLIS L. DONERSON
RJD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

1- State Registrar

Reg. No. 2001 10480

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
Phyllis L. Donerson	MARCH 18, 2001	1823 P M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
PRINCE GEORGES HOSPITAL	SUITLAND	PRINCE GEORGES

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
577-70-3142	1☐M 2☒F	50 Yrs.			Jan. 10, 1951	Wash., D.C.

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Prince George's	Suitland	1☒Yes 2☐No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
3219 Swan Road, #302	20746	United States

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☒Never Married 2☐Married 3☐Widowed 4☐Divorced	1☐Yes 2☒No If Yes, Give Year or Dates: X	1☐Yes 2☒No Specify: X	Specify: Black

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
11th		Home Maker	Private

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Haywood Donerson, Sr.	Lillian Pyles

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Jerome Wilcox, Jr. - Son	3708B Roosevelt Place, N.E. Wash., D.C. 20019

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	Ft. Lincoln Cemetery	3/23/2001	Brentwood, MD

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
John T. Stewart, III	Stewart Funeral Home 4001 Benning Rd., N.E. Wash., D.C. 20019

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Multiple Injuries	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of):	
	c. Due to (or as a consequence of):	
	d. Due to (or as a consequence of):	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month Day Year
1☐Yes 2☐No 9☐Unknown	1☐Live birth 2☐Fetel death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?	24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐Yes 2☐No 3☐Probably 4☒Unknown	1☒Yes 2☐No	1☒Yes 2☐No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☒Yes 2☐No	Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA	Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☐Natural 2☒Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined	3/18/01	1756HR M	1☐Yes 2☒No	Subject was struck by vehicle

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)
roadway	7700 block Silver Hill Road Suitland Maryland

Medical Certification; To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one)
1☐ **Certifying Physician:** To the best of *my* knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☒ **Medical Examiner:** On the basis of examination and/or investigation, in *my* opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
Theodore M. King MD	O.C.M.E.	MARCH 19, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
THEODORE M. King 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
MAR 22 2001	Bernice G. Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23e or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

CR

(5)

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 10481

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: LOUIS JOSEPH D'AMICO

2. Date of Death — Month: March Day: 21 Year: 2001

3. Time of Death: 0227

4a. Facility Name *(If not institution, give street and number)*: WASHINGTON COUNTY HOSPITAL

4b. City, Town, or Location of Death: HAGERSTOWN

4c. County of Death: WASHINGTON

Funeral Director

5. Social Security Number: 055-05-5391

6. Sex: 1☒M 2☐F

7. Age *(In yrs. last birthday)*: 82 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: JAN. 1, 1919

9. Birthplace *(State or Foreign Country)*: NEW YORK

Usual Residence of Decedent

10a. State: MARYLAND

10b. County: WASHINGTON

10c. City, Town or Location: HAGERSTOWN

10d. Inside City Limits: 1☒Yes 2☐No

10e. Street and Number: 1732 EDGEWOOD HILLS CIRCLE, APT. 2

10f. Zip Code: 21740

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐Never Married 2☒Married 3☐Widowed 4☐Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☒Yes 2☐No If Yes, Give Year or Dates: 1944-1946

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* WHITE

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: SUPERVISOR

16b. Kind of Business/Industry: ENGINE MANUFACTURING

17. Father's Name *(First, Middle, Last)*: JOSEPH D'AMICO

18. Mother's Name *(First, Middle, Maiden Surname)*: MARCHESANA GIORDANO

19a. Informant's Name/Relationship *(Type, Print)*: EMMA D'AMICO/WIFE

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 1732 EDGEWOOD HILLS CIRCLE, APT. 2, HAGERSTOWN, MD 21740

20a. Method of Disposition: 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: REST HAVEN CEMETERY

Date: 3/24/01

20c. Location - City or Town, State: HAGERSTOWN, MARYLAND

21. Signature of Funeral Service Licensee: P. Steven Danfelt Jr. P. Steven Danfelt, JR.

22. Name and Address of Facility: REST HAVEN FUNERAL HOME 1601 PENNSYLVANIA AVE., HAGERSTOWN, MD 21742

Physician /Medical Examiner

23e. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Carcinoma of Prostate — 2 years

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initieted events resulting in death) Last

b.

Due to (or es e consequenca of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Generalized Atherosclerosis

Diabetes Mellitus

23b. Did tobacco use contribute to the cause of death? 1☐Yes 2☑No 3☐Probably 4☐Unknown

24a. Wes en autopsy performed? 1☐Yes 2☑No

24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☐No

25. Wes case referred to medical exeminer? 1☐Yes 2☑No

26. Place of Death *(Check only one)*: Hospitel: 1☐Inpatient 2☑ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☐Residenca 6☐Other *(Specify)*

27. Manner of Death: 1☑Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

28a. Dete of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐Yes 2☐No

28d. Describe how injury occurred

28e. Pleca of Injury - At home, farm, street, factory, offica building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner es stated. 2☐ **Medical Examiner:** On the basis of examinetion end/or investigation, in my opinion, death occurred et the time, date end place, and dua to the cause(s) and manner stated.

29b. Signature and title of certifier: Frederic H. Lash, MD

29c. License number: D 27623

29d. Date signed *(Month, Day, Year)*: March 21, 2001

30. Name end address of person who completed cause of death (Item 23a) (Type, Print): Frederic H. Lash, MD 1111 Medical Campus Rd Hagerstown md

State Registrar

31. Date filed *(Month, Day, Year)*: MAR 2 2 2001

32. Registrer's Signeture

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Dennis, Louis

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 10482

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Maurice Albert Dunkle

2. Date of Death Month / Day / Year: 3 / 25 / 01

3. Time of Death: 6-50 AM

4a. Facility Name *(If not institution, give street and number)*: Calvert Memorial Hospital

4b. City, Town, or Location of Death: Prince Frederick

4c. County of Death: Calvert

Funeral Director

5. Social Security Number: 218 22 3459

6. Sex: 1 ☒ M 2 ☐ F

7. Age *(In yrs. last birthday)*: 88 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: April 8 1912

9. Birthplace *(State or Foreign Country)*: North Carolina

Usual Residence of Decedent

10a. State: Maryland

10b. County: Calvert

10c. City, Town or Location: Prince Frederick

10d. Inside City Limits: 1 ☐ Yes 2 ☒ No

10e. Street and Number: 30 Goldstein Road

10f. Zip Code: 20678

10g. Citizen of What Country?: United States

11. Marital Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced

12. Wes Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, apecify Cuben, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify* white

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): ; College (1-4or 5+): 5+

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: superintendent

16b. Kind of Business/Industry: Calvert County Public School

17. Father's Neme *(First, Middle, Last)*: George Dunkle

18. Mother's Name *(First, Middle, Maiden Surname)*: Clara Wolfe

19a. Intormant's Name/Relationship *(Type, Print)*: Frances Poling - daughter

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, Stete, Zip Code)*: 8905 Pensacola Pl. Upper Marlboro MD 20772

20a. Method ot Disposition: 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other *(Specify)*

20b. Piece ot Disposition *(Neme of cemetery, crematory or other pl...)*: Metropolitan Funeral Service

Date: March 27, 2001

20c. Location - City or Town, State: Alexandria Virginia

21. Signature of Funeral Service Licensee: B Rausch

22. Neme end Address of Facility: Rausch Funeral Home PA 4405 Broomes Is. Rd. Port Republic MD 20676

Physician /Medical Examiner

23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode ot dying, such as cardiac or respiretory arrest, shock, or heart tailure. List only one cause on each line.

Approximate Interval Between Onset and Deeth

Immediete Cause (Final disease or condition resulting in death)

a. Coronary artery disease

Due to (or as a consequence of):

Sequentially list conditions, it eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initieted events resulting in death) Last

b.

Due to (or es a consequence of):

c.

Due to (or es e consequence of):

d.

Part II. **Other significant conditione** contributing to death but not resulting in the underlying cause given in Part I.

Chronic obstructive lung disease

Chronic atrial fibrillation

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Wes an autopsy performed? 1 ☐ Yes 2 ☒ No

24b. Were autopsy tindings available prior to completion of cause of death? 1 ☐ Yes 2 ☒ No

25. Wes case referred to medical examiner? 1 ☐ Yes 2 ☒ No

26. Place ot Death *(Check only one)*: Hospital: 1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA; Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other *(Specify)*

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date ot Injury *(Month, Dey Year)*

28b. Time ot Injury M

28c. Injury et Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Piece of Injury - At home, term, street, tactory, office building, etc. *(Specify)*

28f. Location *(Street end Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 ☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, dete and place, and due to the cause(s) and menner as stated. 2 ☐ **Medical Examiner**: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, dete end place, end due to the cause(s) and manner atated.

29b. Signature end title of certifier

29c. License number: D-2535

29d. Date signed *(Month, Day, Year)*: 3/25/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Mukesh Mathur MD Prince Frederick MD 20678

State Registrar

31. Date filed *(Month, Day, Year)*: MAR 28 2001

32. Registrar's Signature: Geneva G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified as soon as possible.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

25

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 10483

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: James Phillip Dalrymple
2. Deta of Death — Month: March Day: 22 Year: 2001
3. Time of Death: 4:48 PM
4e. Facility Neme *(If not institution, give street end number)*: 420 West Dares Beach Road Apt. 410
4b. City, Town, or Location of Death: Prince Frederick
4c. County of Death: Calvert

Funeral Director

5. Social Security Number: 220 28 7105
6. Sex: 1☐M 2☐F — 1 X M
7. Age *(In yrs. last birthday)*: 75 Yrs.
If Under 1 Year — Months: Days:
If Under 24 Hrs. — Hours: Min.:
8. Deta of Birth *(Month, Day, Year)*: July 4, 1925
9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. Stata: Maryland
10b. County: Calvert
10c. City, Town or Location: Prince Frederick
10d. Inside City Limits: 1☐Yes 2☒No
10e. Street and Number: 420 West Dares Beach Road Apt.
10f. Zip Code: 410 20678
10g. Citizen of What Country?: United States

11. Marital Status: 1☐Nevar Married 2☐Married 3☒Widowed 4☐Divorced
12. Was Decedent Evar in U.S. Armed Forcas? 1☐Yas 2☒No If Yes, Give Yaar or Datas:
13. Was Decedant of Hispanic Origin? (Specify Yes or No- If Yas, specify Cuban, Mexicen, Puarto Rican, atc.) 1☐Yes 2☒No *Specify:*
14. Race - American Indien, Black, White, etc. *Specify:* white

15. Decedent's Education *(Specify only highast grada completed)*: Elementary/Secondary (0-12): unknown; College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work dona during most of working life. DO NOT use retired)*: farmer
16b. Kind of Business/Industry: Tobacco

17. Fathar's Name *(First, Middle, Last)*: Phillip Dalrymple
18. Mothar's Nama *(First, Middle, Maiden Surnama)*: Gladys Stinnett

19a. Informant's Neme/Ralationship *(Type, Print)*: June Barbour- daughter
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, Steta, Zip Code)*: P.O. Box 347 Prince Frederick MD 20678

20a. Method of Disposition: X☐Burial 2☐Cremation 3☐Removal from State 4☐Donetion 5☐Othar *(Specify)*
20b. Place of Disposition *(Nama of cematary, cremetory or other piece)*: Wesley Cemetery — Deta: March 26 2001
20c. Location - City or Town, Steta: Prince Frederick Maryland

21. Signature of Funaral Service Licensee: ▶ BRausch
22. Nama and Address of Facility: Rausch Funeral Home PA 4405 Broomes Is. rd. Port REpublic Maryland 20676

Physician /Medical Examiner

23a. Part1. Enter the disease, or complicetions thet caused the death. Do not antar tha moda of dying, such as cerdiec or respiratory arrast, shock, or heart tailura. List only ona causa on each lina.

Approximata Intervai Between Onset and Death

Immedieta Cause (Final disaasa or condition resulting in death): a. Metastatic Rectal Carcinoma

Dua to (or as a consequence of):

Sequentially list conditions, if any, leading to immadiata causa. Enter Underlying Cause (Disease or injury that initiated evants resulting in death) Last:

b.

Due to (or as a consequance of):

c.

Dua to (or as a consequance of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in tha underlying ceusa given in Part I.: Severe Chronic Obstructive Pulmonary Disease

23b. Did tobacco use contribute to the cause of death? 1☒Yes 2☐No 3☐Probably 4☐Unknown

24a. Was an autopsy performed? 1☐Yes 2☒No

24b. Were autopsy findings available prior to completion of cause of death? 1☐Yas 2☒No

25. Was case referred to medical examiner? 1☐Yas 2☒No

26. Place of Death *(Check only one)*: Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA — Other: 4☐Nursing Home 5☒Residence 6☐Othar *(Specify)*

27. Manner of Death: 1☒Natural 2☐Accident 3☐Suicida 4☐Homicida 5☐Pending investigation 6☐Could not be determined

28a. Data of Injury *(Month, Dey Year)*
28b. Time of injury M
28c. Injury at Work? 1☐Yas 2☐No
28d. Describe how injury occurred
28a. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒**Certifying Physician**: To tha best of my knowledge, death occurred at tha time, date and place, and due to tha cause(s) and manner as stated. 2☐**Medical Examiner**: On tha basis of examination and/or investigation, in my opinion, death occurred at tha time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ [signature]
29c. Licensa number: D33123
29d. Date signed *(Month, Day, Year)*: 3-23-01

30. Nama and address of person who completed cause of death (Item 23a) (Type, Print): Jonathan Lowenthal, M.D. Prince Frederick Md. 20678

State Registrar

31. Date filed *(Month, Dey, Year)*: MAR 23 2001
32. Registrar's Signature: [signature] G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 10484

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Robert L. Dyson
2. Date of Death Month Day Year: March 13, 2001
3. Time of Death: 11:30 pm
4a. Facility Name *(If not institution, give street and number)*: Magnolia Gardens Nursing Home
4b. City, Town, or Location of Death: Lanham
4c. County of Death: Prince George's

Funeral Director

5. Social Security Number: 218-56-8566
6. Sex: 1 [X] M 2 [ ] F
7. Age *(In yrs. last birthday)*: 48 Yrs. — If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: Apr 10, 1952
9. Birthplace *(State or Foreign Country)*: DC

Usual Residence of Decedent

10a. State: Maryland
10b. County: Prince George's
10c. City, Town or Location: Lanham
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 8609 Safforn Drive
10f. Zip Code: 20706
10g. Citizen of What Country?: USA
11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White
15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 11; College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Driver
16b. Kind of Business/Industry: Transportation
17. Father's Name *(First, Middle, Last)*: James K. Dyson
18. Mother's Name *(First, Middle, Maiden Surname)*: Sophie E. Charity
19a. Informant's Name/Relationship *(Type, Print)*: Kristy A. Scheufele / Daughter
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 58 Curley Lane, Colonial Beach, VA 22443
20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Metropolitan Crematory
Date: Mar 15 2001
20c. Location - City or Town, State: Alexandria, VA
21. Signature of Funeral Service Licensee: William L Byd
22. Name and Address of Facility: Francis J. Collins Funeral Home, Inc. 500 University Blvd., W, Silver Spring, MD 20901

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Cirrhosis of the Liver — 4 months
Due to (or as a consequence of):
b. Ethanal Hepatitis — 3 years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No
26. Place of Death *(Check only one)*: Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; Other: 4 [X] Nursing Home 5 [ ] Residence 6 [ ] Other *(Specify)*
27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury *(Month, Day, Year)*
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

29e. Certifier *(Check only one)*: 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: William D Rosson MD
29c. License number: D16897
29d. Date signed *(Month, Day, Year)*: March 15, 2001
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): William D. Rosson, MD 5701 85th Ave, New Carrollton, MD 20784

State Registrar

31. Date filed *(Month, Day, Year)*: MAR 2 0 2001
32. Registrar's Signature: Sandra B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 10485

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Carlotta May Drake

2. Date of Death (Month, Day, Year): March 21, 2001

3. Time of Death: 2:30 am

4a. Facility Name (If not institution, give street and number): Mariner Health- Circle Manor

4b. City, Town, or Location of Death: Kensington

4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 216-38-5689

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 58 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Jun 16, 1942

9. Birthplace (State or Foreign Country): Arkansas

Usual Residence of Decedent

10a. State: Maryland

10b. County: Montgomery

10c. City, Town or Location: Kensington

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 10231 Carroll Place

10f. Zip Code: 20895

10g. Citizen of What Country: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No. If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Insurance Sales

16b. Kind of Business/Industry: Insurance

17. Father's Name (First, Middle, Last): Warren Drake

18. Mother's Name (First, Middle, Maiden Surname): Jacqueline Boone

19a. Informant's Name/Relationship (Type, Print): Connie Gartner / Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 25121 Woodfield School Road, Gaithersburg, MD 20882

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, cremetory or other place): Metropolitan Crematory

Date: Mar 22 2001

20c. Location - City or Town, State: Alexandria, VA

21. Signature of Funeral Service Licensee: Robert D. Applegarth

22. Name and Address of Facility: Francis J. Collins Funeral Home, Inc. 500 University Blvd., W, Silver Spring, MD 20901

Physician /Medical Examiner

23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset end Death

Immediete Cause (Final disease or condition resulting in death)
a. Emphysema — 1 year

Due to (or es a consequenca ot):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initieted events resulting in death) Last
b.

Due to (or as a consequenca of):
c.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Peripheral Vascular Disease

Depression

23b. Did tobacco uas contribute to the cause of death? 1☒ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Wes en eutopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings aveilable prior to completion of cause of death? 1☐ Yes 2☒ No

25. Wes case referred to medical examiner? 1☐ Yes 2☒ No

26. Piece of Deeth (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Dete of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury et Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify)

28f. Location (Street end Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, dete end place, and due to the cause(s) and manner es steted. 2☐ **Medical Examiner**: On the basis of exeminetion and/or Investigetion, in my opinion, death occurred at the time, dete and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature]

29c. License number: D 53528

29d. Date signed (Month, Day, Year): March 21, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Daphna Henkin, MD 2309 Shorefield Road, Wheaton, MD 20902

State Registrar

31. Date filed (Month, Day, Year): MAR 23 2001

32. Registrar's Signature: [signature] G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 10486

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Alice L. Derflinger
2. Deta of Death Month Day Year: March 17, 2001
3. Time of Death: 8:30 AM

4e Facility Nama *(If not institution, giva street and number)*: Sunrise Assisted Living
4b. City, Town, or Location of Death: Rockville
4c. County of Deeth: Montgomery

Funeral Director

5. Social Security Number: 233-38-1478
6. Sax: 1☐ M 2☒ F
7. Aga *(In yrs. last birthday)*: 78 Yrs.
If Under 1 Year: Months / Deys
If Under 24 Hrs.: Hours / Min.
8. Dete of Birth *(Month, Day, Year)*: July 30, 1922
9. Birthplace *(State or Foreign Country)*: West Virginia

Usual Residence of Decedent

10a. State: Maryland
10b. County: Montgomery
10c. City, Town or Location: Rockville
10d. Inside City Limits: 1☒ Yes 2☐ No

10a. Street and Number: 1009 Crawford Drive
10f. Zip Code: 20851
10g. Citizen of What Country?: United States

11. Meritel Stetus: 1☐ Naver Merried 2☐ Married 3☒ Widowed 4☐ Divorced
12. Wes Decedent Ever in U.S. Armed Forces? 1☐ Yas 2☒ No If Yas, Giva Year or Detes:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puarto Rican, atc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indien, Bleck, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementery/Secondary (0-12): 8 / College (1-4or 5+):
16a. Decedent's Usuel Occupation *(Giva kind of work done during most of working life. DO NOT use retired)*: Homemaker
16b. Kind of Businass/Industry: Own Home

17. Fathar's Name *(First, Middla, Last)*: Jesse A. Bryant
18. Mother's Nema *(First, Middle, Meiden Sumema)*: Hattie B. Jack

19e. Informent's Neme/Ratelionship *(Type, Print)*: Karen D. Williamson/Cousin
19b. Meiling Address *(Street and Number or Rurel Route Number, City or Town, Stete, Zip Code)*: 1009 Crawford Drive, Rockville, Maryland 20851

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removel from Stete 4☐ Donetion 5☐ Othar *(Specify)*
20b. Piece of Disposition *(Neme of cemetery, crematory or othar piece)*: Parklawn Memorial Park
Deta: March 21, 2001
20c. Location - City or Town, Stete: Rockville, Maryland

21. Signeture of Funerel Service Licensee: Robert A. Pumphrey M00198
22. Name and Address of Facility: Robert A. Pumphrey Funeral Home/Rockville, Inc. 300 West Montgomery Avenue Rockville, Maryland 20850-2805

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or raspiretory arrest, shock, or heart feilure. List only one ceuse on eech line.

Approximata Interval Between Onsat and Death

Immediete Ceuse (Finel disease or condition resulting in death)
a. Renal Failure — Mos

Due to (or as a consequance of):
b. Hypertension — YRS

Sequentially list conditions, if any, leeding to immediete causa. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last
Due to (or es a consequence of):
c. Insulin dependant Diabetes — YRS

Due to (or es a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contributa to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only ona)*: Hospitel: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Homa 5☐ Residence 8☒ Other *(Specify)* Assisted Living

27. Mennar of Deeth: 1☒ Netural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Panding investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury M
28c. Injury at Work? 1☐ Yas 2☐ No
28d. Describe how injury occurred
28e. Piece of Injury - At home, farm, street, factory, office building, atc. *(Specify)*
28f. Location *(Street end Number or Rural Route Number, City or Town, Stata)*

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To tha best of my knowledge, daath occurred at the tima, data and place, end due to tha causa(s) end manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, daath occurred at the time, data and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: S. Rao
29c. Licensa number: D35792
29d. Dete signed *(Month, Day, Year)*: March 19, 2001

30. Name end address of person ~~who completed~~ causa of daath (Item 23a) (Type, Print): Swaroop G. Rao, M.D. 50 West Edmonston Drive, Rockville, Maryland 20852

State Registrar

31. Date filed *(Month, Day, Year)*: MAR 2 0 2001
32. Registrar's Signature: Brenda G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or items 23a or 28d show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 10487

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Robin Leigh Davis
2. Date of Death (Month Day Year): March 15, 2001
3. Time of Death: 7:00 am
4a. Facility Name (If not institution, give street and number): 14429 Parkvale Road
4b. City, Town, or Location of Death: Rockville
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 218-50-5193
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 51 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Feb 14, 1950
9. Birthplace (State or Foreign Country): Connecticut

Usual Residence of Decedent

10a. State: Maryland
10b. County: Montgomery
10c. City, Town or Location: Rockville
10d. Inside City Limits: 1☐ Yes 2☒ No
10a. Street and Number: 14429 Parkvale Road
10f. Zip Code: 20853
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Mail Clerk
16b. Kind of Business/Industry: US Government

17. Father's Name (First, Middle, Last): Frank Ellis Butterfield
18. Mother's Name (First, Middle, Maiden Surname): Winifred Musch

19a. Informant's Name/Relationship (Type, Print): Calvin C. Davis, Jr. / Husband
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 14429 Parkvale Road, Rockville, MD 20853

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Metropolitan Crematory
Date: Mar 18 2001
20c. Location - City or Town, State: Alexandria, VA

21. Signature of Funeral Service Licensee: ▶ Andrew J. Cole
22. Name and Address of Facility: Francis J. Collins Funeral Home, Inc. 500 University Blvd., W, Silver Spring, MD 20901

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Ovarian Cancer — 1 year
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☒ Residence 8☐ Other (Specify)

27. Manner of Death: 1☒ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Dennis M. Hannon MD
29c. License number: D23174
29d. Date signed (Month, Day, Year): MARCH 18, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Dennis Hannon, MD 1396 Piccard Drive, Rockville, MD 20850

State Registrar

31. Date filed (Month, Day, Year): MAR 20 2001
32. Registrar's Signature: ▶ Geneva G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 10488

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: FRANCES DAVIS

2. Date of Death Month / Day / Year: 03 -15-2001

3. Time of Death: 8:20A.M.

4a. Facility Name *(If not Institution, give street and number)*: CARRIAGE HILL BETHESDA

4b. City, Town, or Location of Death: BETHESDA

4c. County of Death: MONTGOMERY

Funeral Director

5. Social Security Number: 577-28-2606

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 84 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Feb.28,1917

9. Birthplace *(State or Foreign Country)*: Washington,D.C.

Usual Residence of Decedent

10a. State: Maryland

10b. County: Prince George's

10c. City, Town or Location: Greenbelt

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 126 Northway Road

10f. Zip Code: 20770

10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 / College (1-4or 5+): 5+

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Editor

16b. Kind of Business/Industry: N.I.H. Record

17. Father's Name *(First, Middle, Last)*: Mark Raum

18. Mother's Name *(First, Middle, Maiden Surname)*: Anna Gann

19a. Informant's Name/Relationship *(Type, Print)*: Mark J. Davis - son

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: same as #10a - 10g

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Adas Israel Cemetery

Date: 3/19/2001

20c. Location - City or Town, State: Washington, D.C.

21. Signature of Funeral Service Licensee: ▶ [signature]

22. Name and Address of Facility: Donald V. Borgwardt Funeral Home, P.A. 4400 Powder Mill Rd. Beltsville, Maryland 20705

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Aspiration Pneumonia — 14 d

Due to (or as a consequence of):

Sepsis

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Dementia

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ [signature]

29c. License number: D40216 (MD)

29d. Date signed *(Month, Day, Year)*: March 15, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Dennis Cullen, M.D. 5454 Wisconsin Ave., #1625 Chevy Chase, Maryland 20815

State Registrar

31. Date filed *(Month, Day, Year)*: MAR 2 0 2001

32. Registrar's Signature: ▶ [signature]

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

ADMEND ITEM: # 23 PART I, PER PHY G794 4-3-01 WR

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 10489

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Dey Year	3. Time of Death
John L. Doyle	February 20, 2001	9:40 am

4a Facility Name (If not Institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Washington Adventist Hospital	Takoma Park	Montgomery

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year Months / Deys	If Under 24 Hrs. Hours / Min.	8. Dete of Birth (Month, Dey, Year)	9. Birthplace (Stete or Foreign Country)
294-07-5405	1☒ M 2☐ F	82 Yrs.			Dec 11, 1918	Ohio

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Prince George's	Hyattsville	1☐ Yes 2☒ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
7500 West Park Drive	20783	USA

11. Marital Stelus	12. Was Decedenl Ever in U.S. Armed Forces?	13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Bieck, White, etc.
1☐ Never Merried 2☒ Merried 3☐ Widowed 4☐ Divorced	1☒ Yes 2☐ No If Yes, Give Year or Dates: WWII	1☐ Yes 2☒ No Specify:	Specify: White

15. Decedent's Edueetion (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12		Division Chief	Labor Department

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surneme)
William F. Doyle	Anna G. Stief

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code)
Martha H. Doyle/ Wife	7500 West Park Drive, Hyattsville, MD 20783

20a. Method of Disposition	20b. Place of Disposition (Neme of cemetery, cremetory or other piece)	Date	20c. Location - City or Town, State
1☒ Burial 2☐ Cremelion 3☐ Removei from State 4☐ Donation 5☐ Other (Specify)	Gate of Heaven Cemetery	Feb 23 2001	Silver Spring, MD

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ William F Bl	Francis J. Collins Funeral Home, Inc. 500 University Blvd., W, Silver Spring, MD 20901

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiec or respiretory arrest, shock, or heart failure. List only one cause on each line. CEREBRAL VASCULAR ACCIDENT — Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death) ~~Cardio Respiratory failure. CVA.~~

Due to (or as a consequence of): CONGESTIVE HEART FAILURE

Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. ~~HTN, CHF, Arrythmia~~

Due to (or as e consequence of): ARRYTHMIA

c.

Due to (or as a consequence of): HYPERTENSION

d.

Part II. **Other signiflcant conditione** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☒ Yes 2☐ No 3☐ Probably 4☐ Unknown

24e. Was an autopsy performed?	24b. Were autopsy tindings available prior to completion of ceuse of death?
1☐ Yes 2☒ No	1☐ Yes 2☐ No

25. Was case referred to medicel examiner?	26. Place of Death (Check only one)	
1☒ Yes 2☐ No	Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA	Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Dey Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☐ Natural 2☒ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined		M	1☐ Yes 2☐ No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)

29a. Certifier (Check only one) 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the besis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner steled.

29b. Signature and title of certifier	29c. License number	29d. Dale signed (Month, Dey, Year)
▶ Suresh Khetan	D0055403	2/21/01 at 2:30pm

30. Name and address of person who completed ceuse of death (Item 23a) (Type, Print)

Suresh Khetan , MD 7610 Carroll Ave., Takoma Park, MD 20912

State Registrar

31. Date filed (Month, Day, Year)	32. Registrer's Signature
FEB 23 2001	▶ Geneva D. Sparks

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Amend #'s 4a.10e.10g.& 19b.Per FH PGC 3-23-01 cr **Certificate of Death** Reg. No. 2001 10490

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Ethel Mary Eaton
2. Date of Death: Month March Day 19 Year 2001
3. Time of Death: 2:08 A.M.

4a. Facility Name (If not Institution, give street and number): 12319 Stonehaven Lane T-22
4b. City, Town, or Location of Death: Bowie
4c. County of Death: Prince George's

Funeral Director

5. Social Security Number: 215 33 8638
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 90 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Nov. 7, 1910
9. Birthplace (State or Foreign Country): England

Usual Residence of Decedent

10a. State: Maryland
10b. County: Prince George's
10c. City, Town or Location: Bowie
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 12319 Stonehaven Lane T-22
10f. Zip Code: 20715
10g. Citizen of What Country? ~~United States~~ England

11. Marital Status: 1☐ Never Married 2☐ Married ☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+): 0
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker
16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): Arthur Willmott
18. Mother's Name (First, Middle, Maiden Surname): Augusta Clark

19a. Interment's Name/Relationship (Type, Print): Marian Goodrich Daughter
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 12319 Stonehaven Lane (T-22) Bowie Maryland 20715

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): The Huntt Crematory
Date: 3/20/01
20c. Location - City or Town, State: Waldorf Maryland

21. Signature of Funeral Service Licensee: Robert E. Evans
22. Name and Address of Facility: Robert E. Evans Funeral Home, Inc. 16000 Annapolis Rd. Bowie Maryland 20715

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. ALZHEIMER'S Disease	>10 years
Due to (or as a consequence of):	b. CACHEXIA	6 months
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. B12 deficiency anemia	>10 years
Due to (or as a consequence of):	d. ARTHRITIS type DJD	>20 years

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. **Did tobacco use contribute to the cause of death?** 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Alain G. Champaloux MD
29c. License number: D42049
29d. Date signed (Month, Day, Year): March 19, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Alain. G. CHAMPALOUX MD Upper Marlboro. MD 20772

State Registrar

31. Date filed (Month, Day, Year): MAR 2 0 2001
32. Registrar's Signature: Jeanne G. Spath

DHMH 16 Rev 6/95

ORIGINAL

To be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

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To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 10491

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
Arvilla Kearney Estep	March 19, 2001	1555 M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Anne Arundel Medical Center	Annapolis	Anne Arundel

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
217-44-5195	1☐M 2☒F	57 Yrs.			Mar. 30, 1943	Connecticut

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Md.	Anne Arundel	Gambrills	1☐Yes 2☒No

10e. Street and Number	10f. Zip Code	10g. Citizen of Whet Country?
2230 Mt. Tabor Road	21054	USA

11. Merital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Bleck, White, etc.
1☐Never Married 2☐Married 3☒Widowed 4☐Divorced	1☐Yes 2☒No If Yas, Give Year or Dates:	1☐Yes 2☒No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired)	18b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12		Homemaker	Own home

17. Father's Name (First, Middle, Last)	18. Mother's Neme (First, Middle, Meiden Sumame)
Martin Kennedy Kearney	Mary Tirendi

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Lisa Walsh daughter	2230 Mt. Tabor Rd., Gambrills, Md. 21054

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, cremetory or other piece)	Date	20c. Location - City or Town, Stete
1☐Buriel 2☒Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	Metropolitan Crematory	03-22-01	Alexandria, VA.

21. Signature of Funeral Service Licensee ▶ Robert M Beall

22. Name and Address of Facility Beall Funeral Home
6512 N.W. Crain Hwy., Bowie, Md. 20715

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on eech line.

Approximate Intervel Between Onset and Death

Immediete Cause (Final diseese or condition resulting in death)
a. Pituitary Tumor
Due to (or as e consequence of):
b.
Due to (or as a consequence of):
c.
Due to (or as e consequence of):
d.

Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last

IF FEMALE: 23b. Was decedent pregnent in the past 12 months? 1☐Yes 2☐No 9☐Unknown	23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 3☐Ectopic pregnency 4☐Pregnant et time of death 5☐Other (specify) 9☐Unknown	23d. Dete of delivery Month Dey Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco usa contribute to the cause of deeth? 1☐Yes 2☒No 3☐Probebly 4☐Unknown

24a. Was en autopsy performed? 1☐Yes 2☒No	24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☒No

25. Was case referred to medical exeminer? 1☐Yes 2☒No	28. Place of Death (Check only one) Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Menner of Deeth 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury et Work? 1☐Yes 2☐No	28d. Describe how injury occurred
	28e. Piece of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date end piece, and due to the cause(s) and manner es steted.
2☐ **Medical Examiner:** On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) end menner stated.

29b. Signature and Title of certifier	29c. License number	29d. Date signed (Month, Dey, Yaar)
▶	D55187	March 21, 2001

30. Name and address of persoo who completed cause of death (Item 23a) (Type, Print)
Aimee Yu 64 Franklin Street, Annapolis, MR 21401

State Registrar

31. Date filed (Month, Dey, Year)	32. Registrar's Signature
MAR 22 2001	▶ Barbara G. Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

(5)

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 10492

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Gholamhassan Ejtemai

2. Date of Death (Month, Day, Year): March 10, 2001

3. Time of Death: 6:45 A. M.

4a. Facility Name *(If not institution, give street and number)*: Ft. Washington Medical Center

4b. City, Town, or Location of Death: Ft. Washington

4c. County of Death: Prince Georges

Funeral Director

5. Social Security Number: 224-67-7723

6. Sex: 1 [X] M 2 [ ] F

7. Age *(In yrs. last birthday)*: 87 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: December 13, 1913

9. Birthplace *(State or Foreign Country)*: Turkanestan

Usual Residence of Decedent

10a. State: Maryland

10b. County: Prince Georges

10c. City, Town or Location: Ft. Washington

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 12331 Hatton Point Road

10f. Zip Code: 20744

10g. Citizen of Whet Country?: Iran

11. Maritel Stetus: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Wes Decedent Ever In U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Yeer or Detes:

13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No *Specify:*

14. Race - Amertcan Indien, Bleck, White, etc. *Specify:* Caucasian

15. Decedent's Education *(Specify only highest grade completed)*: Elementery/Secondary (0-12): 12 | College (1-4or 5+):

16a. Decedent's Usuel Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Self employed farmer

16b. Kind of Business/Industry: Farming

17. Fether's Neme *(First, Middle, Last)*: Mohamad Ejtemai

18. Mother's Neme *(First, Middle, Maiden Surname)*: Mohamdof Eshgabad

19a. Informant's Neme/Reletionship *(Type, Print)*: Hossein Ejtemai / Son

19b. Meiling Address *(Street end Number or Rural Route Number, City or Town, State, Zip Code)*: 12331 Hatton Point Road, Ft. Washington, MD 20744

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donetion 5 [ ] Other *(Specify)*

20b. Placa of Disposition *(Neme of cemetery, cremetory or other place)*: Mt. Comfort Cemetery

Date: March 12, 2001

20c. Location - City or Town, Stete: Alexandria, Virginia

21. Signeture of Funerel Service Licensee: Dennis A. Pittman

22. Name end Address of Fecility: Jefferson Funeral Chapel 5755 Castlewellan Dr., Alexandria, Virginia 22315

Physician /Medical Examiner

23a. Pert1. Enter the disease, or complications thet caused the deeth. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heert teilure. List only one ceuse on eech line.

Approximate Intervel Between Onset end Deeth

Immediete Ceuse (Finel disease or condition resulting in deeth)
e. atrial Fibrilation — unknown

Due to (or as e consequence of):
Hypertension — unknown

Sequentially list conditions, if any, leeding to Immediete cause. Enter Underlying Ceuse (Diseese or Injury that Initieted events resulting in deeth) Last
b.

Due to (or as e consequence of):
c.

Due to (or es e consequence of):
d.

Part II. **Other signtficant conditions** contributing to death but not resulting in the underlying cause given in Pert I.

Coma
Hypernatriemia

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [✓] Unknown

24a. Wes en eutopsy pertormed? 1 [ ] Yes 2 [✓] No

24b. Were autopsy findings eveilable prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Wes case referred to medical exeminer? 1 [ ] Yes 2 [✓] No

26. Piece of Deeth *(Check only one)*: Hospitel: 1 [✓] Inpatient 2 [ ] ER/Outpetient 3 [ ] DOA | Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other *(Specify)*

27. Menner of Deeth: 1 [✓] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigetion 6 [ ] Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury

28c. Injury et Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Piece of Injury - At home, ferm, street, fectory, offica building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29e. Certifier *(Check only one)*: 1 [✓] **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, date end plece, end due to the ceuse(s) and manner as stated. 2 [ ] **Medicat Examiner:** On the basis of examinetion end/or investigetion, In my opinion, deeth occurred et the time, dete end plece, and due to the cause(s) end menner steted.

29b. Signeture end title of certifier: Arastoo Yazdani

29c. License number: D50454

29d. Date signed *(Month, Day, Year)*: March, 10, 2001

30. Neme and eddress of person who completed cause of death (Item 23e) (Type, Print): ARASTOO YAZDANI 9801 Georgia Avenue Suite 3-35 Silver Spring maryland 20902

State Registrar

31. Dete filed *(Month, Day, Year)*: MAR 22 2001

32. Registrer's Signeture: D. Sparks

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the **Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.

To the **Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 10493

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Edgar N. Edwards

2. Date of Death: Month 3 Day 19 Year 2001

3. Time of Death: 9:50p

4a. Facility Name (If not institution, give street and number): Fairland Nursing and Rehabilitation Center

4b. City, Town, or Location of Death: Silver Spring

4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 578-10-7493

6. Sex: XX 1 M 2 F

7. Age (In yrs. last birthday): 96 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): OCT. 25, 1904

9. Birthplace (State or Foreign Country): MARYLAND

Usual Residence of Decedent

10a. State: MARYLAND

10b. County: MONTGOMERY

10c. City, Town or Location: SILVER SPRING

10d. inside City Limits: 1 Yes XX No

10e. Street and Number: 4714 ASPEN HILL ROAD

10f. Zip Code: 20853

10g. Citizen of What Country?: UNITED STATES OF AMERICA

11. Marital Status: 1 Never Married 2 Married 3 Widowed 4 XX Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 XX No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 XX No Specify:

14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 12th

College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): BUS DRIVER

16b. Kind of Business/Industry: METRO TRANSIT

17. Father's Name (First, Middle, Last): SAMUEL EDWARDS

18. Mother's Name (First, Middle, Maiden Surname): BLANCHE THOMPSON

19a. Informant's Name/Relationship (Type, Print): JEANETTE L. BALL (DAUGHTER)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4714 ASPEN HILL ROAD; ROCKVILLE, MARYLAND 20853

20a. Method of Disposition: 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 XX Other (Specify) ENTOMBMENT

20b. Place of Disposition (Name of cemetery, cremetory or other place): FORT LINCOLN CEMETERY

Date: MAR. 22, 2001

20c. Location - City or Town, State: BRENTWOOD, MARYLAND

21. Signature of Funeral Service Licensee: James D. Schwartz

22. Name and Address of Facility: HINES-RINALDI FUNERAL HOME, INC. 11800 NEW HAMPSHIRE AVENUE SILVER SPRING, MARYLAND 20904-2891

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Myocardial Infarction — 1d

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 X Unknown

24a. Was an autopsy performed? 1 Yes 2 X No

24b. Were eutopsy findings available prior to completion of cause of death? 1 Yes 2 X No

25. Was case referred to medical examiner? 1 Yes 2 X No

26. Place of Death (Check only one)

Hospital: 1 Inpatient 2 ER/Outpetient 3 DOA

Other: 4 X Nursing Home 5 Residence 6 Other (Specify)

27. Manner of Death: 1 X Natural 2 Accident 3 Suicide 4 Homicide 5 Pending Investigation 6 Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work? 1 Yes 2 No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 X **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner es stated. 2 **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated.

29b. Signature and title of certifier: Bennett So MD

29c. License number: D54488

29d. Date signed (Month, Day, Year): 3-20-2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Bennett So, MD, 8317 Cherry Ln, Laurel, MD 20707

State Registrar

31. Date filed (Month, Day, Year): MAR 21 2001

32. Registrar's Signature: Geneva G. Sparks

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 10494

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)			2. Date of Death Month Day Year	3. Time of Death
Nello	J.	Fraticelli	March 19, 2001	0925 A

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Calvert Manor Healthcare Center	Rising Sun	Cecil

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
221-01-9036	1☒ M 2☐ F	82 Yrs.			June 17, 1918	Delaware

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Delaware	New Castle	Wilmington	1☒ Yes 2☐ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
412 South Union Street	19805	United States

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced	1☒ Yes 2☐ No If Yes, Give Year or Dates: WWII	1☐ Yes 2☒ No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
9		Stockman	Automotive

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Franco Fraticelli	Angeline Lanzi

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Frank Fraticelli/Son	32 Warren Drive, Elkton, Maryland 21921

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)	Cathedral Cemetery	March 23 2001	Wilmington, Delaware

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ David S. Hicks	Hicks Home for Funerals, P.A. 103 W. Stockton St., Elkton, MD 21921

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Arteriosclerotic cardiovascular disease	2 yrs
	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b.	
	Due to (or as a consequence of):	
	c.	
	Due to (or as a consequence of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Dementia

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐ Yes 2☒ No	1☐ Yes 2☐ No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)
1☐ Yes 2☒ No	Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined		M	1☐ Yes 2☐ No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one) 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ Neil R Taylor MD	D-11115	March 19-01

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)
Neil R Taylor Jr Calvert Healthcare Center, Rising Sun, MD 21911

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
MAR 21 2001	▶ D. Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 10495

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): John A. Fischer

2. Date of Death: Month March Day 23 Year 2001

3. Time of Death: 0038

4a. Facility Name (If not institution, give street and number): Union Hospital

4b. City, Town, or Location of Death: Elkton

4c. County of Death: Cecil

Funeral Director

5. Social Security Number: 291-32-6039

8. Sex: 1 ☑ M 2 ☐ F

7. Age (In yrs. last birthday): 80 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): August 15, 1920

9. Birthplace (State or Foreign Country): New York

Usual Residence of Decedent

10a. State: Maryland

10b. County: Cecil

10c. City, Town or Location: Elkton

10d. Inside City Limits: 1 ☐ Yes 2 ☑ No

10e. Street and Number: 472 Red Hill Road

10f. Zip Code: 21921

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☑ No Specify:

14. Race - American Indian, Black, White, etc. Specify: white

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4or 5+): 7

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Doctor

16b. Kind of Business/Industry: Medical

17. Father's Name (First, Middle, Last): Henry Fischer

18. Mother's Name (First, Middle, Maiden Surname): Daisy Wallace

19a. Informent's Name/Relationship (Type, Print): Joan F. Schweizer, Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1012 Willowleaf Way, Potomac, Maryland 20854

20a. Method of Disposition: 1 ☑ Buriel 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Oblate Sisters Cemetery

Date: March 26, 2001

20c. Location - City or Town, State: Childs, Maryland

21. Signature of Funeral Service Licensee: [signature]

22. Name and Address of Facility: Lee Funeral Home, 259 E. Main Street, Elkton, Maryland 21921

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than 'natural', or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

John Fischer

Physician /Medical Examiner

rgw

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. congestive heart failure — 2 weeks

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. coronary artery disease — years

Due to (or as a consequence of):

c. hypertension — years

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one): Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ☒ Neturel 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

29a. Certifier (Check only one): 1 ☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: W. Bruce Obenshain, MD

29c. License number: D0035779

29d. Date signed (Month, Day, Year): March 24, 2001

50

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): 251 S. Bohemia Ave. Cecilton, Md. 21913 W. Bruce Obenshain, MD

State Registrar

31. Date filed (Month, Day, Year): MAR 2 6 2001

32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 10496

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Duayne Walter Fischer
2. Date of Death (Month Day Year): March 25, 2001
3. Time of Death: 2:00 pm
4a. Facility Name (If not institution, give street and number): St. Mary's Nursing Center
4b. City, Town, or Location of Death: Leonardtown
4c. County of Death: St. Mary's

Funeral Director

5. Social Security Number: 213-84-2968
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 42 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Jan. 9, 1959
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: MD
10b. County: St. Mary's
10c. City, Town or Location: Charlotte Hall
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 37550 Oaks Road
10f. Zip Code: 20622
10g. Citizen of What Country?: U. S. A.

11. Marital Status: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: '77-'81
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexicen, Puerto Ricen, etc.): 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+): 2
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Mechanic
16b. Kind of Business/Industry: Automobile

17. Father's Name (First, Middle, Last): John H. Fischer
18. Mother's Name (First, Middle, Maiden Surname): Carole P. Walter

19a. Informant's Name/Relationship (Type, Print): Carole P. Fischer / Mother
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 37550 Oaks Road Charlotte Hall, Maryland 20622

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): MD Veterans Cemetery | Date: March 30, 2001
20c. Location - City or Town, State: Cheltenham, Maryland

21. Signature of Funeral Service Licensee: Joseph Bart Sothoron
22. Name and Address of Facility: Brinsfield-Echols Funeral Home, P.A. 30195 Three Notch Rd. Charlotte Hall, MD 20622

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. (Approximate Interval Between Onset and Death)

Immediate Cause (Final disease or condition resulting in death):
a. Pulmonary embolism - hypoxemia
Due to (or as a consequence of):
b. long term immobilization
Due to (or as a consequence of):
c. Cervical spine fracture with quadriplegia 15 yr.
Due to (or as a consequence of):
d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Hepatitis C

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | Other: 4 [X] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: John F. Fenwick
29c. License number: D01380
29d. Date signed (Month, Day, Year): 3-26-01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): John F. Fenwick, M.D. St. Mary's Medical Arts Bldg. Leonardtown, MD 20650

State Registrar

31. Date filed (Month, Day, Year): MAR 27 2001
32. Registrar's Signature: Donna G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 10497

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Ethel May Fritter
2. Date of Death Month Day Year: March 19, 2001
3. Time of Death: 7:20 AM
4a. Facility Name *(If not institution, give street and number)*: 38155 Beach Road
4b. City, Town, or Location of Death: Coltons Point
4c. County of Death: St. Mary's

Funeral Director

5. Social Security Number: 578-09-3799
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 102 Yrs. — If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: May 17, 1898
9. Birthplace *(State or Foreign Country)*: Virginia

Usual Residence of Decedent

10a. State: Maryland
10b. County: St. Mary's
10c. City, Town or Location: Coltons Point
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 38155 Beach Road
10f. Zip Code: 20626
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 5th; College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Sales Person
16b. Kind of Business/Industry: Retail Clothes

17. Father's Name *(First, Middle, Last)*: William Tolson
18. Mother's Name *(First, Middle, Maiden Surname)*: Gertrude Sullivan

19a. Informant's Name/Relationship *(Type, Print)*: Jean E. Dieux (Daughter)
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 16000 Sycamore Lane, Rockville, Maryland 20853

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Fort Lincoln Cemetery
Date: 3/24/01
20c. Location - City or Town, State: Brentwood, Maryland

21. Signature of Funeral Service Licensee: Michael Kevin Gardiner
22. Name and Address of Facility: Mattingley-Gardiner Funeral Home, P.A. P.O. Box 270, Leonardtown, Maryland 20650

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death):
a. Cardiopulmonary Failure — Due to (or as a consequence of):
b. Cardiomyopathy — Due to (or as a consequence of):
c. — Due to (or as a consequence of):
d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Approximate Interval Between Onset and Death: hrs / months

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☒ Residence 8☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29e. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: James P. Jarboe M.D.
29c. License number: D 06419
29d. Date signed *(Month, Day, Year)*: 3-19-01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): James P. Jarboe, MD — Hollywood, Maryland 20636

State Registrar

31. Date filed *(Month, Day, Year)*: MAR 20 2001
32. Registrar's Signature: Brenna B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Amend Item#7 Per F.H. 3-22-2001 HCHD LM

Certificate of Death

Reg. No. 2001 10498

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): GERTRUDE BERNADETTE FISHER
2. Date of Death: Month MARCH Day 18 Year 2001
3. Time of Death: 8:00 P.M.

4a. Facility Name (If not institution, give street and number): MARINER HEALTH OF FOREST HILL
4b. City, Town, or Location of Death: FOREST HILL
4c. County of Death: HARFORD

Funeral Director

5. Social Security Number: 215-01-9244
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): ~~85~~ 86 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 2/24/1915
9. Birthplace (State or Foreign Country): Md.

Usual Residence of Decedent

10a. State: Md.
10b. County: Harford
10c. City, Town or Location: Bel Air
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 300 Sunflower Drive, Apt. 115
10f. Zip Code: 21014
10g. Citizen of What Country? U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: white

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 4th grade; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work dona during most of working life. DO NOT use retired): homemaker
16b. Kind of Business/Industry: own home

17. Father's Name (First, Middle, Last): Elmer L. Cole
18. Mother's Neme (First, Middle, Maiden Surname): Margaret V. Whelan Cole

19a. Informent's Name/Relationship (Type, Print): M. Patricia Romeo
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1910 Angleside Road, Fallston, Md. 21047

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Ramoval from State 4☐ Donation 5☐ Othar (Specify)
20b. Placa of Disposition (Name of cemetery, crematory or other place): Parkwood Cemetery
Date: 3/22/01
20c. Location - City or Town, State: Baltimore, Md.

21. Signature of Funeral Servica Licensee: ▶ Brian A. Miller
22. Neme end Address ot Fecility: Schimunek Funeral Home of Bel Air, Inc. 610 W. MacPhail Road, Bel Air, Md. 21014

Physician /Medical Examiner

23a. Part1. Enter the disaasa, or complications that caused the daath. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or haart tailura. List only ona cause on aach line. (Approximata Intervel Between Onset and Death)

Immediata Cause (Final disease or condition resulting in death): a. MULTIINFARCT DEMENTIA — 2 YEARS

Due to (or as a consequenca of):

Sequentially list conditions, if any, taading to immediata cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in death) Last:
b.
Due to (or as a consequance ot):
c.
Due to (or as a consequenca ot):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings aveilable prior to completion of cause ot death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yas 2☒ No

26. Placa of Death (Check only ona): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☒ Nursing Home 5☐ Residenca 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Data of Injury (Month, Day Year)
28b. Time ot Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Placa ot Injury - At homa, tarm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, Stata)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the tima, data and place, and due to tha causa(s) and mannar as stated. 2☐ **Medical Examiner:** On tha basis ot examination and/or investigation, in my opinion, daath occurred at tha time, data and place, and dua to the cause(s) and mennar stated.

29b. Signature end titie of certifier: ▶ Andrew Nowakowski MD
29c. License number: DO 80796
29d. Date signed (Month, Day, Year): MARCH 20 2001

30. Name and address of person who completed cause ot death (Item 23a) (Type, Print): ANDRON NOWAKOWSKI MD 125 N. MAIN ST BELAIR, MD 21014

State Registrar

31. Data filad (Month, Day, Year): MAR 22 2001
32. Registrar's Signature: ▶ Donna B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 10499

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: CHARLIE FISHER

2. Date of Death: Month March Day 15 Year 2001

3. Time of Death: 1892

4a. Facility Name *(If not institution, give street and number)*: Northwest Hospital 5401 Old Court Road

4b. City, Town, or Location of Death: RANDALLSTOWN

4c. County of Death: BALTIMORE

Funeral Director

5. Social Security Number: 240-34-1974

6. Sex: 1 [X] M 2 [ ] F

7. Age *(In yrs. last birthday)*: 71 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: DEC 25, 1929

9. Birthplace *(State or Foreign Country)*: NC

Usual Residence of Decedent

10a. State: MD

10b. County: BALTIMORE

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1 [X] Yes 2 [ ] No

10e. Street and Number: 2835 Cunningham Drive

10f. Zip Code: 21244

10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [ ] Widowed 4 [X] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: 3/19/51 - 2/28/53

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 / College (1-4or 5+): 4

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Laborer

16b. Kind of Business/Industry: Private Industry

17. Father's Name *(First, Middle, Last)*: UNKNOWN

18. Mother's Name *(First, Middle, Maiden Surname)*: Clinnie Fisher

19a. Interment's Name/Relationship *(Type, Print)*: Daughter Gwendolyn M. Fisher-Jacobs

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 2835 Cunningham DR. Baltimore, MD. 21244

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Hillcrest Cemetery

Date: 3/23/01

20c. Location - City or Town, State: Clinton, NC

21. Signature of Funeral Service Licensee: Leander M. Coles

22. Name and Address of Facility: T&F-State F/S 108 W. North Avenue, Baltimore MD

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. ACUTE INFERIOR MI

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. ASCVD

Due to (or as a consequence of):

c. COPD ANXIETY

Due to (or as a consequence of):

d. HTN

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death *(Check only one)*: Hospital: 1 [ ] Inpatient 2 [X] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other *(Specify)*

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Dr. Laura Harlan

29c. License number: H0051339

29d. Date signed *(Month, Day, Year)*: March 15, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Dr. Laura J. Harlan 54a Old Ct. Rd. Randallstown MD 21133

State Registrar

31. Date filed *(Month, Day, Year)*: MAR 20 2001

32. Registrar's Signature: G. Sparks

To Be Completed by Funeral Director

Permit: Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

Medical Certification: To Be Completed by Physician/Medical Examiner

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Division of Vital Records, P.O. Box 68760,

(2)

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 10500

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)		2. Date of Death Month / Day / Year	3. Time of Death
Aldo	Fioravanti	March 15 2001	4:30 P. M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
4618 Lincoln Avenue	Beltsville	Prince George's

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
579-38-3199	1[X] M 2[ ] F	71 Yrs.			June 17, 1929	Washington, DC

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Prince George's	Beltsville	1[X] Yes 2[ ] No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
4618 Lincoln Avenue	20705	U.S.A.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces? If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1[X] Never Married 2[ ] Married 3[ ] Widowed 4[ ] Divorced	1[X] Yes 2[ ] No	1[ ] Yes 2[X] No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	18b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12		Contract Specialist	Organization of American States

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Julius Ulderigo Pasquale Fioravanti	Mabel Vollmer

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Yolanda G. Fioravanti - Sister	4618 Lincoln Avenue, Beltsville, Maryland 20705

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1[X] Burial 2[ ] Cremation 3[ ] Removal from State 4[ ] Donation 5[ ] Other (Specify)	Fort Lincoln Cemetery	03/20/2001	Brentwood, Maryland

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
[signature]	Gasch's Funeral Home, P.A. 4739 Baltimore Avenue, Hyattsville, MD 20781

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Cancer of Colon	18 Months
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of):	
	c. Due to (or as a consequence of):	
	d. Due to (or as a consequence of):	

IF FEMALE: 23b. Was decedent pregnent in the past 12 months?	23c. If yes, outcome of pregnency	23d. Date of delivery Month / Day / Year
1[ ] Yes 2[ ] No 9[ ] Unknown	1[ ] Live birth 2[ ] Fetel death 3[ ] Ectopic pregnancy 4[ ] Pregnent at time of death 5[ ] Other (specify) _____ 9[ ] Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?	24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1[ ] Yes 2[X] No 3[ ] Probably 4[ ] Unknown	1[ ] Yes 2[X] No	1[ ] Yes 2[ ] No

25. Was case referred to medical examiner?	28. Place of Death (Check only one)	
1[ ] Yes 2[X] No	Hospital: 1[ ] Inpatient 2[ ] ER/Outpatient 3[ ] DOA	Other: 4[ ] Nursing Home 5[X] Residence 8[ ] Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1[X] Natural 2[ ] Accident 3[ ] Suicide 4[ ] Homicide 5[ ] Pending investigation 6[ ] Could not be determined		M	1[ ] Yes 2[ ] No	
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28l. Location (Street and Number or Rural Route Number, City or Town, State)

29e. Certifier (Check only one)
1[X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2[ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
[signature]	D25914	March 16, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Allen Brimmer, M.D. 12201 Plum Orchard Drive, Silver Spring, Maryland 20904

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
MAR 2 0 2001	[signature]

DHMH 17 Rev 1/2001

ORIGINAL

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To be Completed by Funeral Director

Baltimore, Maryland 21215-0036

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